

Employee Benefits Survey Form

- 1 What are the coverages you are currently insured for? (Pls Circle)
Life: Group Term Life / Group Critical Illness / Group Accidental Death
& Dismemberment
Medical: Group Hospital & Surgical / Group Major Medical
Medical: Outpatient General Practitioner (GP) / Outpatient
Specialist
Practitioner (SP) / Dental
- 2 When was your Employee Benefits Insurance last reviewed? _____
- 3 Did the company make any enhancements over the last 3 years to be aligned with
coverage change?
Yes No
- 4 Estimated Company Headcount:
Local / PR: _____
Foreigner: _____
- 5 Any feedback on existing Intermediary / Agent service level?
(i.e. turn around time for claims, admin etc)

- 6 Current insurer and Intermediary / Agent:

Company name: _____
Name: _____ Gender: Male / Female
Rank & Title: _____
Contact No: (Office) _____ Mobile Hp: _____
Email: _____
Address: _____
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Thank you.

Enterprise Solutions Division
Prudential Assurance Company Singapore (Pte) Limited
Reg No: 199002477Z
Email : SGP.Employee.Benefit.AgencyBDM@prudential.com.sg