PERSONAL HEALTH DECLARATION FORM

STATEMENT PURSUANT TO FINANCIAL SERVICE ACT 2013, Section 129, Schedule 9, Para 5: It is the duty of the customer to take reasonable care not to make a misrepresentation to the licensed insurer when answering any question which the insurer may request that are relevant to the decision of the insurer whether to accept the risk or not and the rates and terms to be applied.

ALL QUESTIONS MUST BE FULLY COMPLETED IN BLOCK LETTERS AND IN INK (*Tick ✓ whichever is applicable.)

1. Name of Employer :

Name of Employee : Date Employed : Nationality :

Job Description : Marital Status : Telephone No.:

2. PARTICULARS OF PERSON (S) TO BE INSURED

ITEM	NAME OF PERSON	SEX	DATE OF BIRTH	NEW IC / BC / PASSPORT NO.	HEIGHT (CM)	WEIGHT (KG)	PLAN
EMPLOYEE							
SPOUSE							
1ST CHILD							
2ND CHILD							
3RD CHILD							
4TH CHILD							

3. a. Has an application for medical, disabilities or life insurance on you or any dependants ever been declined, postponed or accepted at other than normal terms? [ ] Yes [ ] No

b. Have you or any of your dependants ever made a claim against any insurance company in respect of any medical or disability insurance policy? [ ] Yes [ ] No

NOTE: If the answer to any of the above Questions 3(a) to 3(b) is "Yes", please give details below.

QN	NAME OF PERSON	INSURANCE COMPANY	TYPE OF INSURANCE / CLAIM	AMOUNT OF CLAIM / CONDITION (S)

4. Do you or any of your dependants engage or have any prospect of being involved in any hazardous sport, pastime activities or occupation (e.g. racing, diving, etc.)? If “Yes”, please give full details: [ ] Yes [ ] No

5. Have you or any of your dependants ever been under continuous medical treatment, been hospitalized, undergone surgical operation or advised to do so or suffered a serious accident or poisoning? If “Yes”, please give full details: [ ] Yes [ ] No

0121

6. Have you or any of your dependants ever had or been treated for any of the following illnesses or troubles:

a. Affections of the lungs, heart, circulatory organs, nervous system, digestive system and / or genitourinary system (e.g. asthma, high / low blood pressure, epilepsy, gastric ulcer, diabetes, high cholesterol, blood in urine, etc.)? [ ] Yes [ ] No

b. Affections of the ears, eyes, nose, bones, joints or spine? [ ] Yes [ ] No

c. Any other disease, infection, physical defect, or any circumstances not mentioned above which may affect the risk of this plan on any of the persons to be insured (such as swollen glands, tumour, cancer, etc.)? [ ] Yes [ ] No

NOTE: If the answer to any of the questions 6(a) to 6(c) is "Yes", please give details below.

QN	NAME OF PERSON	MEDICAL CONDITIONS	WHEN ? DURATION ? RECOVERED ? AFTER EFFECTS ?

7. For Females only (Please tick✓) [ ] Proposer [ ] Spouse:

a. Are you now pregnant? [ ] Yes [ ] No

b. Are you suffering or have you ever suffered from any disorder of the female organs (breasts, uterus, ovaries) or periodic pains such that you required medical treatment or any complications in any previous pregnancies? [ ] Yes [ ] No
If "Yes", please give full details:

8. When was the last time you or your dependants consulted a doctor and for what purpose? Please state the name and address of the doctor.

DECLARATIONS

I/we hereby confirm that I/we have taken reasonable care to answer all the questions herein honestly and to the best of my/our knowledge, belief and recollection and that I/we shall remain under a continuous duty to inform the Company of any change, amendment or addition to the aforesaid questions until the Policy is issued and comes into effect. I/we understand that the Company may void the policy and reject any claim payable thereunder (whether in whole or in part) in the event of a deliberate misrepresentation, misdescription, error, omission or non-disclosure of fact (whether or not there was an inquiry/question raised pertaining to the same) with or without an intention to defraud the Company by me/us which would have affected the premium payable or the acceptance of the risk by the Company.
I, herewith authorise any doctor or any other person whom the insurance company may approach to disclose to the company or its medical department all information they may require in connection with the proposed insurance. A photocopy of this authorisation shall be considered as effective and valid as the original.

_____ _____
Date (Day / Month / Year) Signature of Employee

This form is duly completed and signed by the above named employee.

_____ _____
Name & Date Signature of Employer or Authorized Officer
(Please affix company stamp)

0121