

Comprehensive Personal Accident Insurance Proposal Forms

Important Notice

- Pursuant to Section 149(4) of the Insurance Act (Malaysia) 1996, you are to disclose in this Proposal Form, fully and faithfully all the facts, which you know or ought to know otherwise, the policy issued may be void.
- If there is insufficient space to complete an answer, please attach a signed and dated addendum. Any documents attached shall form part of this proposal form.

Individual Proposer		Company Proposer	
Title		Company Name	
Name			
MyKad No.		Company Registration No.	
Army / Police / Passport No.		Date of Company Registration	
Gender	Date of Birth		
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Contact Person	
Occupation		Nature of Business	
Phone No. (Mobile/House/Office)		Fax No.	E-Mail
Correspondence Address			
Postcode	Town	State	

To be filled by Individual Proposer only

Education Level	<input type="checkbox"/> Primary	<input type="checkbox"/> Secondary	<input type="checkbox"/> Diploma	<input type="checkbox"/> Bachelor Degree
	<input type="checkbox"/> Master	<input type="checkbox"/> Doctorate	<input type="checkbox"/> Professional	
No. of children in family (please indicate the number)	<input type="checkbox"/> 0 - 12 years	<input type="checkbox"/> 12 years to 18 years	<input type="checkbox"/> 18 years +	
Monthly Household Income	<input type="checkbox"/> Up to RM1,500	<input type="checkbox"/> RM1,501 - RM2,500	<input type="checkbox"/> RM2,501 - RM5,000	<input type="checkbox"/> RM5,001 - RM8,000
	<input type="checkbox"/> RM8,001 - RM15,000	<input type="checkbox"/> RM15,001 - RM20,000	<input type="checkbox"/> RM20,001 +	

Details of Coverage Required

1. Period of Insurance from _____ to _____

2. Details of Person to be Insured

Name	Date of Birth
MyKad No.	Other ID No.
Occupation	Phone No (Mobile/House/Office)

3. Coverage required

No	Results	Sum Insured (RM)	Premium (RM)
1	Permanent Disablement		
2	Death		
3	Temporary Total Disablement		
4	Medical Expenses		
5	Temporary Partial Disablement		
		Amount Due (including Stamp Duty)	



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4. Does the Proposer wish to make a nomination? Yes No
 If "Yes", please complete the Nomination Form as provided together with the Certificate document.

Other Information

1. a. Are You engaged in Manual Work? Yes No
 b. Do You supervise in Manual Work? Yes No
 c. Does Your occupation require the use of machine? Yes No
 If "Yes", please give details _____
 d. Do you engage in any hazardous sports or activities involving additional risk of accident? Yes No
 If "Yes", please give details _____
2. a. To the best of Your knowledge and belief, do You suffer any physical or other defect or weakness of any kind? Yes No
 If "Yes", please give details _____
 b. Have You ever suffered from any serious injuries, disease during the last five (5) years? Yes No
 If "Yes", please give details _____
 c. To the best of Your knowledge are You at the present in good health? Yes No
 If "No", please give details _____
 d. Are You at present covered/insured against Personal Accident with other Insurer/Takaful Operator? Yes No
 If "Yes", please state the Name of the Insurer/ Takaful Operator, Sum Insured /Amount of Coverage and Policy/Certificate No.

3. Has any takaful operator/insurance company in respect of any of the perils to which this proposal relates
- a. Declined to cover/insure you? Yes No
 b. Required special terms to cover/insure you? Yes No
 c. Cancelled or refused to renew your takaful/insurance? Yes No
 If 'Yes' for any of item above, please give details _____

Declaration

I/We hereby declare that the information given is true and complete to the best of my/our knowledge and believe that all material information affecting the assessment of this application have been disclosed.

I/We understand that this insurance will not be enforced until and unless this proposal has been accepted by Etiqa Insurance Berhad.

Signature of Proposer / Company Stamp _____

Date _____

Verification Of Proposer's Identity

In Compliance With Section 16/2 Of The Anti-Money Laundering Act 2001

I/We hereby certify that the Proposer's original MyKad/Business Registration Certification was verified and authenticated by me/us at the Point of Sales.

Third Party Verification*

Name of Officer/Intermediary _____

Signature _____

MyKad No / Business Registration Certification _____

Date _____

* "Third Party" means by Insurance Agents, Insurance Brokers or staff of Insurance Companies.

Note:

To retain a copy of MyKad for Applicant(s)/Proposer(s) for Individual Policy Insurance where the premium is exceeding RM50,000.00 per annum and a copy of Business Registration Certificate for Group Policy Insurance is exceeding RM100,000.00 per annum.

For Office Use

Source : HQ / Branch _____

Sales Channel Code : _____

Channel : _____

Sales Channel Name : _____