

HEALTH DECLARATION - Application for Reinstatement, Policy Changes or Addition

Important Notes: 1) Pursuant to Section 149 (4) of the Insurance Act 1996, you are to disclose fully and faithfully, all the facts which you know or ought to know, otherwise the application may be invalidated. 2) **ETIQA INSURANCE BERHAD** reserves the right to request for further requirements as and when necessary.

Policy No _____	Have you made any payment with this application? Yes / No _____ RM _____		
A. PERSONAL PARTICULARS		LIFE ASSURED	
ASSURED / POLICYOWNER			
Full Name (as stated in I.C.) _____	_____	_____	
Occupation (Exact Duties): _____ Industry: _____	_____	_____	
Height (without shoes) _____	_____ cm OR _____ kaki/ft _____ in	_____ cm OR _____ kaki/ft _____ in	
Weight _____ Any gain or loss in weight in the last 12 months? Please indicate the changes.	_____ kg OR _____ lbs Yes / No _____	_____ kg OR _____ lbs Yes / No _____	
B. HEALTH DETAILS (Please tick 'YES' or 'NO')		LIFE ASSURED	
		ASSURED / POLICYOWNER	
		Yes	No
		Yes	No
1. Have you been engaged or planned to engage in any hazardous activities or sports as a career or hobbies or races or aviation or flying other than as fare paying passenger on a regular schedules airline? (E.g. : scuba diving, rock climbing, motor racing, military force handling explosive, etc...). If 'YES', please provide details in section C.			
2. Are you currently on treatment for or have you ever been diagnosed with or treated for or advised to seek treatment for a disease, injury, disability, physical defect, physical deformity or sequels thereof such as but not limited to cardiovascular diseases, stroke, high blood pressure, cancer, eye diseases, diseases of the liver, the kidney(s), the digestive tract or the respiratory tract, metabolic disorders, diabetes mellitus, diseases of the musculoskeletal system, neurological disorders, congenital diseases or abnormality, paralysis, mental or psychiatric disorders, tuberculosis, HIV/AIDS or alcoholism etc. or any other diseases not named above, by a medical doctor / professional? If 'YES', please provide details in section C.			
3. Have any of your immediate family members ever had or died from a hereditary disease such as but not limited to heart disease, stroke, high blood pressure, cancer, liver disease, kidney disease, diabetes, paralysis, epilepsy, mental disease, tuberculosis or AIDS (Acquired Human Immunodeficiency Syndrome)? If 'YES', please provide details in section C.			
4. In the past 5 years, have you ever been advised to have any medical / diagnostic test (such as blood or urine test, ECG, X-rays, ultrasound or CT scans, biopsy, etc, operation, medical advice or hospital treatment? If 'YES', please state Name of hospital/Clinic visited, Date of consultation and admission, Nature of Problems and diagnosis, type of treatment or test performed with result in section C.			
5. What assurance is now in force on your life? (including accident and hospital assurance) Please indicate company, plan, amount of insurance and date of issue? Have you applied for any insurance policy that has been declined, postponed, modified or is now pending? If 'YES', please state what companies, date and cause in section C.			
6. Do you now smoke cigarettes or have you smoked any cigarettes in the past twelve months? If 'YES', please state how many sticks per day in section C?			
7. FEMALE ONLY Are you pregnant? If 'YES', please state how many month in section C? Have you been told by a doctor of any likely complications at delivery?			
C. If any answer to the above stated question is YES, please state question number and provide details below.			
LIFE ASSURED		ASSURED / POLICYOWNER	
<p>I/WE HEREBY declare that I/WE have read the application or the same was interpreted to me and the answers entered in the application are mine/ours and I/WE HEREBY CERTIFY on behalf of myself/ourselves and of any person who may have or claim any interest in said policy, each of the above answers to be fully complete and true, and I/WE AGREE that they shall, with the following Agreements be taken as the basis of the proposed reinstatement, change or addition. I/WE FURTHER AGREE that any reinstatement, change or addition shall not take into effect irrespective of any monies paid pursuant thereto, until the same shall have been approved by an authorized officer of the company. I/WE FURTHER AGREE that if the said policy be reinstated, the Incontestability and Suicide Provisions thereof shall be deemed and held to be so modified as to have effect from such approval date instead of the date of issue or the last reinstatement date of the said policy. Furthermore, I/WE hereby authorized any doctors, hospital, clinic, insurance company or other organization, institution or person, that has any records including any personal records which includes identifications of my/our signature or knowledge of me/us or my/our health, to disclose to ETIQA INSURANCE BERHAD or its representative all information about me/us with reference to my/our health and medical history and any hospitalization, advise, treatment, disease or ailment. A copy of this authorization shall be as effective and valid as original.</p>			
Dated at : _____ this day : _____ of 20 _____			
Signature of Witness : _____ Name : _____ NRIC No : _____ Phone No : _____ Address : _____	Signature of Life Assured : _____ Name : _____ NRIC No : _____ Phone No : _____ Address : _____	Signature of Policy Owner: _____ (if applicable) Name : _____ NRIC No : _____ Phone No : _____ Address : _____	

No Reinstatement is allowed under MAJOR MEDILIFE & MEDILIFE PLUS
Note: Any changes must be signed by Life Assured and Policy Owner.

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