

MediLove Proposal Form

IMPORTANT NOTE

Pursuant to Paragraph 5 of Schedule 9 of the Financial Services Act 2013, if you are applying for this Insurance wholly for yourself/family/dependants, you have a duty to take reasonable care not to make a misrepresentation in answering the questions in this Proposal Form. You must answer the questions in this Proposal Form fully and accurately.

Failure to take reasonable care in answering the questions may result in avoidance of your contract of insurance, refusal or reduction of your claim(s), change of terms or termination of your contract of insurance.

The above duty of disclosure shall continue until the time your contract of insurance is entered into, varied or renewed with us.

In addition to answering the questions in this Proposal Form, you are required to disclose any other matter that you know to be relevant to our decision in accepting the risks and determining the rates and terms to be applied.

You also have a duty to tell us immediately if at any time after your contract of insurance has been entered into, varied or renewed with us any of the information given in this Proposal Form is inaccurate or has changed.

AGENCY CODE _____

Please use block letters / tick (✓) in appropriate box

1. Your Personal Particulars:

Salutation MR MDM MISS

Name of Applicant / Proposer : _____

Correspondence Address : _____

_____ City _____ Postcode _____

Tel No. (Home) : _____ (H / P) _____

NRIC No / Passport No : _____ Old IC no (if applicable) _____

Date of Birth :

D	D	M	M	Y	Y	Y	Y
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 Sex Male Female

Nationality Malaysian Others _____

Race Malay Chinese Indian Others

Preferred Language English Malay Chinese Tamil

2. Proposed Insured Particulars:

Name _____

Date of Birth _____ NRIC No / Passport No _____

Sex Male Female Weight _____kg Height _____cm

Smoker No Yes _____ (How many sticks per day)

Occupation _____ Relationship to the Applicant _____

Nature of Work

- Persons engaged in professional, administrative, managerial, clerical and non-manual occupation
- Persons engaged in work of supervisory nature but not involved in manual labour
- Persons engaged either occasionally or generally in manual work which involves the use of tools or machinery
- Full time student / housewife / pensioner

3. Medical Health Questionnaire

No.	Question	Yes	No
1	Does the person to be insured have Health Insurance with us or any other company?		
2	Does the person to be insured require takeover benefit from other Health Insurance? If YES, please attach a copy the existing Policy Schedule.		
3	Has person to be insured ever in respect of any medical or health insurance, had an insurer defer or decline a proposal, refuse renewal or terminate insurance? If YES, please state reason and provide the name of the insurance company.		
4	Has person to be insured:		
	a. Suffered from any physical impairment, infirmity or abnormality or congenital conditions?		
	b. Had or ever been advised to have any medical check-up, x-ray scan, blood test, urine test, ECG or is currently under observation and/or receiving treatment or taking any medication in the past twelve (12) months?		
	c. Has or had any abnormal blood, urine or any other investigation test result in the past twelve (12) months?		
	d. Undergone any surgical operation or suffered any illness, disorder or injury during the past three (3) years which has required any form of medical or specialized examination or consultation or hospitalization, or that may require future treatment?		
	e. Seen a doctor / specialist for medical or surgical advise, diagnostic test or investigation including test or treatment that has not been performed or completed?		
	f. Had any surgery planned in the next six (6) months?		
5	Has the person to be insured ever suffered from or been treated, told by or consulted a medical practitioner for:		
	a. Disease or disorder of the eyes, ears, nose, mouth or throat?		
	b. Fits, epilepsy, recurrent dizziness or headache, fainting, sclerosis, mental or nervous disorder, paralysis, depression, psychiatric or psychological disorders, blackout or of any kind?		
	c. Persistent cough, coughing blood, asthma, bronchitis, tuberculosis or any other disorders of respiratory disorder?		
	d. High or low blood pressure, heart disease, chest pain or discomfort or tightness, heart attack, stroke, shortness of breath, rheumatic fever, anaemia or disorder of blood, other disease of the heart or blood vessels or any form of circulatory disorder, palpitation or any other disorders of the heart?		
	e. Stone or any other disorder of kidney or urinary system, sugar, protein or blood in urine or menstrual disorder?		
	f. Rheumatism, slipped disc, arthritis, gout or disorder of muscles or joints, spinal disorder or back pain, skin disorder?		
	g. Gastritis, ulcer or any other disorders of stomach or intestine, prostate conditions, haemorrhoids or hernia?		
	h. Diabetes mellitus, thyroid conditions?		
	i. Liver disorder or disease, gall bladder stone or any other disorder of gall bladder, hepatitis of any kind or jaundice?		

No.	Question	Yes	No
	j. Tumours, cancer, cysts, nodules, polyps, growth and lumps of any kind including malignant blood/ leukemia?		
	k. Varicose veins or deep vein thrombosis?		
	l. HIV (Human immunodeficiency virus), AIDS (acquired immunodeficiency syndrome) or other sexually transmitted disease?		
	m. Any illness, disease, injury, disabilities or amputation not mentioned above?		
6	Female applicants: Is the person to be insured now pregnant? If YES, how many month? _____ months		
7	For children below two (2) years old: Was this child born premature or pre-term? If YES, please provide birth weight and number of weeks premature.		
8	Has or had any of person to be insured's parents or sibling suffered from/died from cancer, diabetes mellitus, hypertension, stroke, kidney disease, multiple sclerosis, mental illness or any other heredity disease or other serious condition or disease?		

9. If any of the answer to question 3 to 8 is 'YES' please give details in the box below and state the number of the question to which the answer is applicable or leave blank if the answer is 'NO'

Question No.
Name of Person
Type and Date of Disability
Current Status of Disability
Name and Address of Hospital / Clinic and Physician

Question No.
Name of Person
Type and Date of Disability
Current Status of Disability
Name and Address of Hospital / Clinic and Physician

Question No.
Name of Person
Type and Date of Disability
Current Status of Disability
Name and Address of Hospital / Clinic and Physician

10. a. My usual or last visit Doctor

Hospital Specialist Centre Clinic

b. Name of Hospital / Specialist Centre / Clinic _____

c. Address _____
_____ Tel _____

d. Date of visit _____

e. Reason for visit to usual or last visited Doctor.

Additional

- We may ask you additional questions if required.
- The questions on this proposal form and any other details we specifically request relate to facts which we consider material to underwriting this insurance. However, because no list of questions can be exhaustive, please consider whether there is any other material information which is known to you which could influence our assessment and acceptance of the risk.

Proposed Insured : Age (Next birthday)	
Plan No.	

Premium	RM
Tax (where applicable)	RM
Stamp Duty	RM 10.00
Total Payable	RM

*The premium is subject to an additional stamp duty RM 10 and Tax (where applicable).

IMPORTANT NOTICE

All premium and fees shown in this document may be subject to tax or other government levies.

DECLARATION

I/We understand that it is my/our duty to take reasonable care not to make a misrepresentation in answering the questions in this Proposal Form and I/We hereby declare that I/We have fully and accurately answered the questions above.

I/We hereby authorise any hospital, surgeon, medical practitioner or clinic or other person who attended to me/ourselves for any reason to disclose to the Insurance Company any and all information with respect to any illness or injury and to provide copies of all hospital or medical records/certifications, including any earlier medical history. A photo-copy of this authorization shall be considered as effective and valid as the original.

I/We acknowledge that the liability of the Insurance Company does not commence until this proposal is approved, premium paid to the Insurance Company and the policy is issued.

DECLARATION BY PROPOSER

I/We hereby give my/our unconditional and unequivocal consent to you and all your related Companies to process my/our personal data revealed hereto. You are at liberty to process the data and share the information revealed thereto with any of your service providers and your other related Companies provided that the revelation of my/our personal data strictly for the purposes in relation to the insurance which I/we have applied hereto. The consent given hereto is in line with the requirement set forth in the Personal Data Protection Act 2010.

Signature of Proposed Insured
Date (DD/MM/YYYY): _____
Place: _____

Signature of Applicant / Proposer
Date (DD/MM/YYYY): _____
Place: _____

PAYMENT BY CREDIT CARD

I enclose herewith a cheque of RM _____ (Cheque No. _____) being premium inclusive of Stamp Duty made payable to Zurich General Insurance Malaysia Berhad

OR

Please charge RM _____ to my MasterCard Visa

Credit Card Account Number :

- - -

Card Expiry Date: M M - Y Y

Signature of Credit Card Holder
Date(DD/MM/YYYY):_____

FOR OFFICE USE ONLY

Official Receipt No : _____

Total Premium Amount :RM _____

Period of Cover : _____ to _____

(DD/MM/YY) (DD/MM/YY) (DD/MM/YY)

IMPORTANT INFORMATION ON THE PURCHASE OF MEDICAL / HEALTH INSURANCE (MHI)

CHECKLIST

The insurer/intermediary has explained to me the following important features as contained in the policy document of the MHI policy being purchased:

1. The benefits payable under the policy.
2. Significant medical or technical exclusions or restrictions applicable.
3. Limits of benefits (e.g % of cost covered by the policy, co-payment, ceiling to total claim costs, deductible amounts), etc.
4. Nature and extent of the insurer's right to review and revise the premiums payable, and the notice to be given by the insurer in the event of any revision.
5. Pre-existing conditions, specific illness and qualifying period and the relevant periods applicable.
6. Reasonable and customary clause.
7. Amount of premiums payable and the payable term.
8. For yearly renewal policies, whether policy is renewal guaranteed.
9. Conditions that would lead to the following scenarios on the policy renewals:
 - Policy is renewed with increased premium.
 - Policy is renewed with exclusions, excess amount, etc.
 - Policy is not renewed
10. The implications of switching policy from one insurer to another or transferring from one insurance plan to another that may cause the Waiting Period, Specified Illness and Pre-existing Conditions to start afresh or non acceptance of your proposal.
11. The insurer's right to repudiate liability in the event of my failure to disclose relevant information in the proposal form that would affect the decision of the insurer to accept or reject the risk, and on the premiums and terms to be applied to the policy owner.
12. A "cooling off period" of 15 days will be given to me to review the suitability of the newly purchased policy. If I were to return the policy to the insurer during this period, premiums will be refunded after the deduction of expenses, if any.
13. The actual terms and conditions will be in the original policy to be delivered to me once the insurer had written and approved my proposal.
14. Reference on the basics of MHI policies may be obtained from "The Introduction to Medical and Health Insurance Products" issued by Bank Negara Malaysia.

Signature of Proposer/ Applicant

Name : _____

NRIC No.: _____

Date (DD/MM/YY): _____

Signature of Intermediary (Agent)

Name : _____

NRIC No.: _____

Date (DD/MM/YY): _____

SUMMARY INFORMATION SHEET

Note: This information sheet provides a summary of the main features of the above product for illustration purposes and does not constitute a contract of the above insurance. Policyholders are advised to refer to the policy document for full details of the product terms and conditions, including those outlined below.

(A) Terms of Issue

1. This is a Hospital & Surgical (H&S) Policy until age 70.

It is a yearly Renewable Policy which means, the Policy is renewable at the option of the Company. This Policy shall become effective as of the date stated in the Policy Schedule. The Policy Anniversary shall be one year after the effective date and annually thereafter. On each such anniversary, this Policy is renewable at the premium rates in effect at that time as notified by the Company. Applicants for change of benefits to higher plan can only be made on renewal and is subject to acceptance by the Company upon renewal.

The renewal premium payable for the H&S Policy is not guaranteed;

(a) The Company can revise the premium at the time of renewal according to the Company's risk assessment.

(b) The premium rate is age-banded and is payable according to each member's age on each Policy year anniversary.

2. If the Insured Person is hospitalized at a published Room & Board rate which is higher than his/her eligible benefit, the Insured Person shall bear 20% of the other eligible benefits described in the Schedule of Benefits.

3. If the proposal / declaration of the policyholder is untrue or misrepresented / misstated in any respect, then this policy shall be void.

4. Cooling-Off Period may apply if this Policy shall have been issued and for any reason whatsoever the Policyholder shall decide not to take up the Policy, the Policyholder may return the Policy to the Company for cancellation provided such request for cancellation is delivered by the Policyholder to the Company within fifteen (15) days from the date of delivery of the Policy. The Policyholder is entitled to the return of the full premium paid less deduction of medical expenses incurred by the Company in the issuance of the Policy.

(B) Schedule of Benefits and Indicative Premium Rate

Plans	Plan 1 (RM)	Plan 2 (RM)	Plan 3 (RM)	Plan 4 (RM)	Plan 5 (RM)	Plan 6 (RM)
Overall Annual Limit	10,000	20,000	30,000	50,000	100,000	150,000
	(Maximum Per Disability)					
HOSPITAL BENEFITS						
Daily Hospital Room & Board (Max. 200 days)	60	80	120	200	350	450
Intensive Care Unit (Max. 90 days)	120	160	250	400	500	600
Hospital Supplies and Services	**As Charged**					
Operating Theatre	(Subject to Reasonable & Customary Charges)					
SURGICAL BENEFITS	**As Charged**					
Surgical expenses comprising the following but excluding organ transplantation: Pre-Surgical Diagnostic Test (within 60 days prior to admission) Pre-Surgical Specialist Consultation (within 60 days prior to admission) Surgical Fees Anaesthetist Fees	(Subject to Reasonable & Customary Charges)					
MEDICAL BENEFITS	**As Charged**					
Medical expenses for non-surgical treatment, comprising: Pre-Hospital Diagnostic Test (within 60 days prior to admission) Pre-Hospital Specialist Consultation (within 60 days prior to admission) In-hospital Physician Visit (Max. 60 days) Post Hospitalisation Treatment (within 31 days after discharge)	(Subject to Reasonable & Customary Charges)					
OUT-PATIENT BENEFITS	**As Charged**					
Emergency Outpatient Treatment for Accident only (within 24 hours and follow-up treatment to a Max. of 31 days) Outpatient Physiotherapy Treatment (within 90 days after discharge/surgery) Ambulance Fees	(Subject to Reasonable & Customary Charges)					
	200	250	300	500	700	1,000
Monthly Outpatient Kidney Dialysis & Cancer Treatment	1,000	2,000	3,500	4,000	5,000	6,000
ORGAN TRANSPLANTATION						
Heart, Kidney, Lung, Liver, Bone Marrow Transplantation	5,000	12,500	20,000	30,000	50,000	60,000
OTHER BENEFITS						
Daily Government Hospital Cash Allowance (Max.200 days per annum)	25	35	45	50	55	60
Insured Child's Daily Guardian Benefits (Max. 60 days)	25	50	75	100	175	200
Tax On Eligible Expenses	**As Charged**					

Annual Premium

Age Next Birthday

30 days - 17 years
 18 – 35 years
 36 – 45 years
 46 – 55 years
 56 – 60 years
 #61 – 65 years (renewal only)
 #66 – 70 years (renewal only)

Annual Premium With Tax (RM)*					
Premium by individual					
Plan 1	Plan 2	Plan 3	Plan 4	Plan 5	Plan 6
327.02	382.02	450.02	546.02	674.02	833.02
352.02	446.02	525.02	637.02	786.02	897.02
502.02	637.02	750.02	909.02	1,123.02	1,281.02
778.02	986.02	1,161.02	1,409.02	1,739.02	1,986.02
1,153.02	1,463.02	1,723.02	2,090.02	2,581.02	2,946.02
1,604.02	2,035.02	2,396.02	2,908.02	3,590.02	4,098.02
2,156.02	2,735.02	3,220.02	3,907.02	4,824.02	5,507.02

Age Next Birthday

30 days - 17 years
 18 – 35 years
 36 – 45 years
 46 – 55 years
 56 – 60 years
 #61 – 65 years (renewal only)
 #66 – 70 years (renewal only)

Annual Premium With Tax (RM)*					
Premium by non-individual					
Plan 1	Plan 2	Plan 3	Plan 4	Plan 5	Plan 6
345.56	403.86	475.94	577.70	713.38	881.92
372.06	471.70	555.44	674.16	832.10	949.76
531.06	674.16	793.94	962.48	1,189.32	1,356.80
823.62	1,044.10	1,229.60	1,492.48	1,842.28	2,104.10
1,221.12	1,549.72	1,825.32	2,214.34	2,734.80	3,121.70
1,699.18	2,156.04	2,538.70	3,081.42	3,804.34	4,342.82
2,284.30	2,898.04	3,412.14	4,140.36	5,112.38	5,836.36

This product does NOT cover:

1. All Pre-existing Illnesses
2. All Specified Illnesses (120 days only)
 Hypertension, Diabetes Mellitus, Cardiovascular disease, Tumours, Cancers, Cyst, Nodules, Polyps, Stones of the urinary and biliary system, Ear, Nose (including sinuses) and Throat conditions, Hernias, Haemorrhoids, Fistulae, Hydrocele, Varicocele, Endometriosis including disease of the Reproduction system, Veterbro-spinal disorders (including disc) and Knee Conditions.
3. Illnesses that commenced within the Waiting Period of thirty (30) days except for accident injuries.
4. Pregnancy, infertility and all complications arising therefrom
5. Routine Physical examinations, medical check-up, Dental conditions (except by accidental injuries), Plastic / Cosmetic Surgery
6. Congenital Conditions, Circumcision, Organ donation
7. Drugs and Alcohol Abuse, Suicide, Attempted suicide, Psychiatric conditions
8. HIV, AIDS or any HIV / AIDS related conditions; Sexually Transmittal Disease
9. Sleep disorders, Hormone replacement therapy, Alternative treatment
10. Hazardous sports, private flying
11. Any attempt of violation of the law or resistance to lawful arrest
12. Participation in riots and active duty in Armed Forces
13. Any person who resides outside of Malaysia for more than 90 consecutive days while the policy is in force.

DECLARATION BY SALE ADVISOR (AGENT)

Verification of Proposer's Identification

To be completed by Insurance Agents, Insurance Brokers or Staff of Insurance Companies relating to the Anti-Money Laundering & Terrorism Financing Act 2001.

**ANTI-MONEY LAUNDERING, ANTI-TERRORISM FINANCING AND PROCEEDS OF UNLAWFUL ACTIVITIES ACT 2001
(AMLATFPUAA2001)
(VERIFICATION OF IDENTIFICATION OF PROPOSER)**

Name of Proposer _____

Business Registration No. /NRIC No. _____

In compliance with Section 16(3) of the Anti-Money Laundering, Anti-Terrorism Financing and Proceeds of Unlawful Activities Act 2001 (AMLATFPUAA 2001), I hereby certify that the Applicant's original NRIC No/Business Registration Certificate was verified and authenticated by me at the point of sales.

Third Party Verification

Signature of Insurance Agents, Insurance Brokers or Staff of
Insurance Companies

Name

Date

New NRIC No.

Note: A copy of the Proposer's New NRIC/Business Registration Certification for Individual Insurance Policy must be submitted together with this proposal if the Premium exceeds RM50,000

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