MPI GENERALI

MPI Generali Insurans Berhad (14730-X)

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MPI Generali Insurans Berhad is licensed under the Financial Services Act 2013 and regulated by Bank Negara Malaysia.
MPI Generali Insurans Berhad dilesenkan di bawah Akta Perkhidmatan Kewangan 2013 dan dikawal selia oleh Bank Negara Malaysia.

PERSONAL HEALTH DECLARATION FORM

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.

DECLARATION

Name of Policyholder/Employer:		Policy Number:	
Name of Applicant/Employee:	Plan:	NRIC/Passport :	Marital Status:
Nationality:	Home Country:	Date of Birth:	Height : CM
Occupation:	Nature of work:	Gender: Male / Female	Weight : KG

PARTICULARS OF INSURED PERSONS

Name of Insured Person (as in NRIC or Passport) to be included		NRIC or Passport no.	Date of Birth	Gender	Height	Weight
Spouse			DD/MM/YYYY	M/F	CM	KG
Child1	Is this child a full time student in Malaysia? Yes/No		DD/MM/YYYY	M/F	CM	KG
Child2	Is this child a full time student in Malaysia? Yes/No		DD/MM/YYYY	M/F	CM	KG
Child3	Is this child a full time student in Malaysia? Yes/No		DD/MM/YYYY	M/F	CM	KG
Child4	Is this child a full time student in Malaysia? Yes/No		DD/MM/YYYY	M/F	CM	KG
Child5	Is this child a full time student in Malaysia? Yes/No		DD/MM/YYYY	M/F	CM	KG

QUESTIONNAIRE

Please answer the following questions:	Yes	No
1. Have you suffered from any illness, disorder, or injury during the past there (3) years which has required any form of medical or specialized examination or consultation or hospitalization or that may require future treatment?		
2. Currently receiving medical treatment and/or suffering from physical impairment, congenital abnormality or poor health?		
3. Are you currently taking any medication, or do you have any medication prescribed? (If "yes", please provide reason including name of medication, daily dosage and length of treatment?		
4. Have you seen a doctor/specialist for medical or surgical advice, diagnostic test or investigation including test or treatment that has not been performed or completed?		
5. Do you have any other policies in force where a similar benefit may be payable?		
6. Have you ever, in respect of any medical or health insurance, had any insurer defer or decline a proposal, refuse renewal or terminated insurance?		
7. Have a family history of critical illnesses like cancer, kidney failure and others?		

8. Do you smoke any form of tobacco? (if "yes", Please advise type and daily consumption. If "no", please advise how long you have been a non-smoker.		
9. Have you ever suffered from or been treated, told by or consulted a medical practitioner for: （Please "circle"） i. Persistent stomach, abdominal or gastric pain, hernia, ulcer or disease of the stomach, intestine, haemorrhoids/piles or rectal disorder?		
ii. Heart disorder, chest pain or discomfort or tightness, heart attack, stroke, paralysis, high blood pressure, palpitation other diseases of the heart or blood vessels or any form of circulatory disorders?		
iii. Disease of eyes, ears, nose, mouth or throat?		
iv. Arthritis, sciatica, rheumatism, gout or disorder of the muscles or joints, spinal disorder or back pain?		
v. Cancer, tumours, cysts, nodules, polyps, or growth and lumps of any kinds including malignant blood/leukaemia?		
vi. Persistent cough, asthma or shortness of breath, bronchitis, pleurisy, tuberculosis or other respiratory disorder or lung disease?		
vii. Epilepsy, fits, recurrent dizziness or headaches, fainting, sclerosis, depression, anxiety, psychiatric or psychological disorders, mental or nervous disorder, blackout or of any kind?		
viii. Enlarged lymph nodes, skin lesions, HIV or AIDS related conditions or other sexually transmitted disease?		
ix. Anaemia, blood disorder, varicose veins or deep vein thrombosis, thyroid conditions, disorder (such as goiter), rheumatic fever？		
x. Disease of the breast, the reproduction system, menstrual, abnormal pap smear(s) or complication at child-birth?		
xi. High cholesterol, hypercholesterolemia, hyperlipidemia, hyperuricemia, hyperglycemia or abnormal lipid profile?		
xii. Diabetes mellitus, liver disorder or hepatitis of any kind or jaundice, stones in the urinary and biliary systems and cholecystitis? Stones (Calculi) or any disorder of the genito-urinary system (Sex organs and urinary system including kidneys, ureters, bladder, prostate, etc)		
10. For Children below two (2) years old: i. Was this Child born premature or pre-term? ii. What was the birth weight? iii. Duration of hospital stay after birth? iv. Currently, any residual complications or impairment?		

If you have answered "YES' to the above questions 1 to 10, please give details below and number your answers to correspond with the number of the questions.

Question	Name of Insured Persons	Nature of Illness	Date Treated	Present State of Health	Name of Hospital and Doctor

For Question 3	Name of medication	Reason	Daily dosage	Length of treatment

DECLARATION

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

I/ We hereby authorize, any hospital, surgeon, medical practitioner or clinic or other person who attends to me / Insured Person for any reason to disclose to the insurance company any and all information with respect to any illnesses, injury and to provide copies of all hospital or medical records/certifications, including any earlier medical history. A photocopy of this authorization shall be considered as effective and valid as the original.

____________________ Signature of Applicant	________________ Date

Note: The liability of the company does not commence until the application has been accepted.

PERSONAL DATA PROTECTION ACT 2010

MPI Generali Insurans Berhad is committed and have put in place a Privacy Policy to safeguard the security and confidentiality of your personal information with us. In using our services and website, you acknowledge and agree to be bound by the terms of our Privacy Policy and Privacy Notice which is available at mpigenerali.com. A copy of the Privacy Notice will be sent to you together with your insurance Policy upon acceptance of your Propose by Us.