LIBERTY GENERAL INSURANCE BERHAD 197801007153 (44191-P)

Formerly known as AmGeneral Insurance Berhad
Liberty Insurance Tower, CT 9, Pavilion Damansara Heights, 3, Jalan Damanlela, 50490 Kuala Lumpur
Tel. No.: 03-2268 3333 or 1-300-888-990
Website : www.libertyinsurance.com.my

LIBERTY 100 YEARS CARE MAJOR MEDICAL INSURANCE PROPOSAL FORM

Consumer Insurance Contract.

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 the Proposal Form fully and accurately.

Failure to take reasonable care in answering the questions may result in the 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 the Proposal Form is inaccurate or has changed.

INTERMEDIARY :	ACCOUNT NO. :	POLICY NO.:

YOUR PERSONAL PARTICULARS

Name of Proposer: _____

Postal Address: _____

_____

_____Postcode: _____

NRIC No.: _____ Date of Birth: _____ (d) _____ (m) _____ (y)

Nationality: ☐ Malaysian ☐ others: _____ (please specify)

Passport No.: _____ Passport Expiry date: _____

Sex: ☐ Male ☐ Female

Race: ☐ Malay ☐ Chinese ☐ Indian ☐ Others: _____

Marital Status: ☐ Single ☐ Married ☐ Others: _____

No. of Dependants (Spouse/Child/Children) _____

Weight: _____kg Height: _____ cm Mobile Phone No.: _____

Telephone No.: (Home): _____ (Office): _____

E-mail Address: _____

Occupation: _____

Nature of Business: _____

Employer's name: _____

Employer's address: _____

_____

Do you undertake work abroad? ☐ Yes ☐ No

If "Yes" please give details: _____

What is the maximum duration of each assignment abroad: _____?

SST Registration: ☐ Yes ☐ No

If "Yes", please provide SST No. & Registration date: _____

YOUR SPOUSE'S PARTICULARS

Is insurance required for your spouse? ☐ **Yes** ☐ **No**

Name of Spouse: _____

Nationality: ☐ Malaysian ☐ Others _____ (please specify)

Passport No.: _____ Passport Expiry date: _____

NRIC No.: _____ Date of Birth: _____ (d) _____ (m) _____ (y)

Occupation: _____

Sex: ☐ Male ☐ Female

Race: ☐ Malay ☐ Chinese ☐ Indian ☐ Others: _____

Weight: _____kg Height: _____ cm Mobile Phone No.: _____

Telephone No.: (Home): _____ (Office): _____

E-mail Address: _____

Nature of Business: _____

Employer's name: _____

Employer's address: _____

_____

Do you undertake work abroad? ☐ Yes ☐ No

If "Yes" please give details: _____

What is the maximum duration of each assignment abroad: _____?

SST Registration: ☐ Yes ☐ No

If "Yes", please provide SST No. : _____
& Registration date

ANNUAL BUDGET ALLOCATION FOR MEDICAL INSURANCE: RM _____.
Important Note: If you are not providing or choose not to provide this information, we / our branch office / intermediaries may not be able to provide you with the most suitable product recommendations. You are responsible to choose a product which is suitable for your needs. Please ensure the medical coverage of the chosen product suits your needs and priorities, taking into account any existing medical coverage which you may have.

Health Notification

- Please provide a Comprehensive Medical checkup report for those proposer who is 46 years and above. (This condition apply for New Applicants Only)
- The cost of the report shall be borne by the proposer.

CLASSIFICATION OF OCCUPATION

Please tick (√)

Insured	Spouse	Class	Nature of Work
		1	Persons who engage in professional, administrative, management, clerical and non-guide occupations generally.
		2	Persons engaged in work of a supervising guide labour. Persons who travel frequently in the course of their work shall be classified in this Class.
		3	Persons engaged in guide work not of a particularly hazardous nature but involving the use of all types of mechanically-driven apparatus, tools or devices.
		4	Persons engaged in extra-hazardous occupations. Refer Company for the list of occupations.

Note : Loading of 10% and 20% shall apply for Occupational Class 3 & 4 respectively.

YOUR CHILDREN'S PARTICULARS

Is insurance required for your child / children? ☐ **Yes** ☐ **No**

Name1: _____

Date of Birth: ____ (d) _____ (m) ____ (y) NRIC No. / Birth Cert.No.: _____

Sex: ☐ Male ☐ Female

Name 2: _____

Date of Birth: ____ (d) _____ (m) ____ (y) NRIC No. / Birth Cert.No.:_____

Sex: ☐ Male ☐ Female

Name 3: _____

Date of Birth: ____ (d) ____ (m) _____ (y) NRIC No. / Birth Cert.No.:_____

Sex: ☐ Male ☐ Female

Note: If you have more than 3 children, please state the details of each child and attach it with this form

DECLARATION (1)

Please answer the following questions for yourself and your dependents:

		Yes	No
1.	Do you have any other policies in force where a similar benefit may be payable? If yes, kindly provide the said policy schedule/s.		
2.	Have you ever, in respect of any medical or health insurance, had an insurer defer or decline a proposal, refuse renewal, accept at other than normal terms or terminate insurance?		
3.	Are you currently taking any medication or do you have any medication prescribed? (If "YES", please provide reason including the name of medication, daily dosage and length of treatment.)		
4.	Have you suffered from any illness, disorder or injury during the past five (5) years which has required any form or specialized examination or consultation or hospitalization, or that may require future treatment?		
5.	Have you lodged any claim under any health insurance policy in the last five (5) years? If yes, kindly provide full details, continuing on a separate sheet if necessary.		
6.	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?		
7.	Have you ever suffered from or been treated ,or 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 headaches, fainting, sclerosis, mental or nervous disorder, paralysis, depression, anxiety, psychiatric or psychological disorders, blackout of any kind?		
	c) Persistent cough, asthma or shortness of breath, bronchitis, tuberculosis or other respiratory disorder?		
	d) Heart disorder, heart attack, chest pain or discomfort or tightness, palpitation, high blood pressure, stroke, rheumatic fever, anemia or disorder of the blood, other diseases of the heart or blood vessels or any form or circulatory disorders?		
	e) Cancer, tumors, cysts, nodules, polyps, growth and lumps of any kind including malignant blood/leukemia?		
	f) Diabetes, thyroid conditions, hepatitis of any kind or jaundice?		
	g) Rheumatism, a slipped disc, arthritis, gout or disorder of the muscles or joints, spinal disorder or back pain endometriosis or diseases of the reproductive system?		
	h) Persistent stomach, abdominal or gastric pain, acid reflux disease, Irritable Bowel Syndrome, Colitis, Crohn's Disease or other digestive system disorder, hernia, prostate conditions, hemorrhoids or piles?		
	i) Diseases of lungs, brains, kidney, liver, gall bladder?		
	j) Acne, Rosea, Eczema, Psoriasis, or other skin disorder?		
	k) Drug or Alcohol Abuse?		
	l) Elevated Cholesterol?		
	m) Varicose veins or deep vein thrombosis?		
	n) Stones in the urinary and biliary systems and cholecystitis?		
	o) HIV (human immunodeficiency virus), AIDS (acquired immunodeficiency syndrome) or other sexually transmitted disease?		
	p) Any illness, disease, injury, disabilities or amputation not mentioned above? If yes, kindly provide full details, continuing on a separate sheet if necessary.		
8.	Have you and your close relatives suffered heart disease, stroke, cancer, kidney disease, or other serious conditions or disease? If "YES" please provide full details, continuing on a separate sheet if necessary		

9. In the last 5 years, have you seen any health care practitioner, including a naturopath, physiotherapist, chiropractor, physiologist, speech therapist or podiatrist? If yes, describe the type of practitioner and the reason. _____		
10. Have you or any persons to be Insured Person ever undergone any surgery during the past five (5) years		
11. Have you or any person to be Insured Person ever had any surgery planned in the next six (6) months?		
12. Do you or any person to be Insured Person suffer from any physical impairment, infirmity or abnormality or congenital conditions?		
13. Have you or any person to be Insured Person in the past twelve (12) months ever had or been advised to have any electrocardiogram, x-ray, blood or urine test, biopsy or other diagnostic test?		
14. Have you or any person to be Insured Person at any time had any symptoms for more than one (1) week of continuous unexplained recurrent or persistent fever or fatigue , enlarged lymph nodes, chronic or recurrent diarrhea, unusual skin lesions, continuous significant weight loss or weight gain?		
15. Female applicants: • Are you / your spouse now pregnant? If "Yes", please state the stage of pregnancy: _____months • Have you ever had disease of the breast, female organs, abnormal pap smear(s) or complications at child-birth? If the answer is "Yes" to the above questions, please give details below _____		
16. For children below two (2) years old: • -Was this child born premature or pre-term? _____ • -What was the birth weight? _____ kg. • -Duration of hospital stay after birth?_____ • -Currently, any residual complications or impairment? _____ If the answer is" yes" to the above questions, please give details below. _____		
17. 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. _____		
18. Apart from any matter you have already described, are you in and do you generally enjoy good health? (If "No", please provide details below) _____		
19. Does any chronic / long term medical condition exist or is there any other known disability, abnormality or recurrent illness or injury? Please specify: _____		
20. Have you ever been declared bankrupt or insolvent or subject to bankruptcy and insolvency proceedings? Please specify: _____		

IMPORTANT

** Please ensure that you fully disclosed any known or suspected conditions and any symptoms experienced by anybody included in this application. This applies even if profession advise has not been sought. Typical examples are varicose veins, allergies, backache, bunions, piles, gynaecological problems (including any irregularities of menstruation) or any pair swelling or lumps.*

If you answered "Yes" to any of the DECLARATION (1), please provide the following details:

Question 1

Name of Person: _____

Previous / Current Insurer: _____

Policy No.: _____ Expiry Date: _____

Question 2

Name:
_____

Insurance Company: _____

Reason for Declination/Refuse: _____

Special Terms Imposed: _____

Question 3

Name of Person: _____

Nature of Illness: _____

Previous Treatment & Consultation (with date): _____

Name of Doctor & Hospital: _____

Need for Any Future Treatment or Consultation: _____

_____

Present State of Health: _____

Question 4

Name of Person: _____

Nature of Illness: _____

Previous Treatment & Consultation (with date): _____

Name of Doctor & Hospital: _____

Need for Any Future Treatment or Consultation: _____

_____

Present State of Health: _____

Question 5

Name of Person: _____

Nature of Illness: _____

Previous Treatment & Consultation (with date): _____

Name of Doctor & Hospital: _____

Need for Any Future Treatment or Consultation: _____

_____

Present State of Health: _____

Question 6

Name of Person: ____

Nature of Illness: ____

Previous Treatment & Consultation (with date): ______________________

Name of Doctor & Hospital: ______________________________________

Need for Any Future Treatment or Consultation: _____________________

____

Present State of Health: ____

Question 7

Item: ______________

Name of Person: ____

Nature of Illness: ____

Previous Treatment & Consultation (with date): ______________________

Name of Doctor & Hospital: ______________________________________

Need for Any Future Treatment or Consultation: _____________________

____

Present State of Health: ____

Item: ______________

Name of Person: ____

Nature of Illness: ____

Previous Treatment & Consultation (with date): ______________________

Name of Doctor & Hospital: ______________________________________

Need for Any Future Treatment or Consultation: _____________________

____

Present State of Health: ____

Item: ______________

Name of Person: ____

Nature of Illness: ____

Previous Treatment & Consultation (with date): ______________________

Name of Doctor & Hospital: ______________________________________

Need for Any Future Treatment or Consultation: _____________________

____

Present State of Health: ____

Item: ______________

Name of Person: ____

Nature of Illness: ____

Previous Treatment & Consultation (with date): ______________________

Name of Doctor & Hospital: ______________________________________

Need for Any Future Treatment or Consultation: _____________________

____

Present State of Health: ____

Question 8

Name of Person: ____

Nature of Illness: ____

Previous Treatment & Consultation (with date): ______________________

Name of Doctor & Hospital: ______________________________________

Need for Any Future Treatment or Consultation: _____________________

____

Present State of Health: ____

Question 9

Name of Person: ____

Nature of Illness: ____

Previous Treatment & Consultation (with date): ______________________

Name of Doctor & Hospital: ______________________________________

Need for Any Future Treatment or Consultation: _____________________

____

Present State of Health: ____

Question 10

Name of Person: ____

Nature of Illness: ____

Previous Treatment & Consultation (with date): ______________________

Name of Doctor & Hospital: ______________________________________

Need for Any Future Treatment or Consultation: _____________________

____

Present State of Health: ____

____

Question 11

Name of Person: ____

Nature of Illness: ____

Previous Treatment & Consultation (with date): ______________________

Name of Doctor & Hospital: ______________________________________

Need for Any Future Treatment or Consultation: _____________________

____

Present State of Health: ____

Question 12

Name of Person: ____

Nature of Illness: ____

Previous Treatment & Consultation (with date): ______________________

Name of Doctor & Hospital: ______________________________________

Need for Any Future Treatment or Consultation: _____________________

____

Present State of Health: ____

Question 13

Name of Person: _____

Nature of Illness: _____

Previous Treatment & Consultation (with date): _____

Name of Doctor & Hospital: _____

Need for Any Future Treatment or Consultation: _____

_____

Present State of Health: _____

Question 14

Name of Person: _____

Nature of Illness: _____

Previous Treatment & Consultation (with date): _____

Name of Doctor & Hospital: _____

Need for Any Future Treatment or Consultation: _____

Present State of Health: _____

IMPORTANT NOTE (1)

- 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 known to you which could influence our assessment and acceptance of the risk.

Any other material information provided by the Proposer?

Please specify: _____

Please tick (√) the required plan:

COMPREHENSIVE	☐ **Plan A**
	☐ **Plan B**
	☐ **Plan C**

PREMIUM COMPUTATION

Particulars		**Annual Premium**
Proposer		RM
Spouse		RM
Children	*1*	RM
	2	RM
	3	RM
	4	RM
	5	RM
	6	RM
Loading		RM
Family Discount (FD) : Insured & Spouse (5%) Insured & Children (5%) Insured & Spouse & Children (10%)		RM
Total		RM
Services Tax		RM
Stamp Duty (per policy)		RM 10.00
Grand Total		**RM**

DECLARATION (2)

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 authorize any hospital, surgeon, medical practitioner or clinic or other person who attended to me/us for any reason to disclose to the Insurance Company 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 photocopy 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 accepted by and premium paid to the Insurance Company.

My usual doctor / physician is: _____ Address: _____

_____

_____

_____

Tel: _____

_____ _____

Signature of Proposer Date

PAYMENT INSTRUCTIONS

I enclose herewith cash for RM_____ being premium inclusive of Stamp Duty made payable to **LIBERTY GENERAL INSURANCE BERHAD** OR

Please charge RM _____ to my ☐ MasterCard ☐ Visa ☐ Debit

Credit/ Debit Card Account No.:_____ Expiry Date: _____

_____ Signature of Proposer
*if by Card, Proposer must be Cardmember and signature as per Card Account

_____ Date

*** CASH BEFORE COVER REQUIREMENT:**

No cover shall be granted until premium has been paid or received by Liberty General Insurance Berhad in accordance with the CASH-BEFORE-COVER Regulations.

ACKNOWLEDGEMENT

No.	CHECKLIST (please tick the box (as) where appropriate)	Yes	No
A.	The insurer/intermediary has briefed me on the content of the booklet. "The Introduction to Medical and Health Insurance Products" (issued by Bank Negara under the Consumer Education Programme) and I have been given a copy of the booklet.		
B.	The insurer/intermediary has explained to me the following important features as contained in the policy document of the MEDICAL INSURANCE PLAN policy being purchased:-		
	1. Benefits payable under the policy.		
	2. Significant medical or technical exclusions or restrictions applicable.		
	3. Limits of benefits (e.g. % of costs covered by the policy, co-payment, ceiling to total claim costs, deductible amounts, etc).		
	4. Amount of premiums payable and the payable term.		
	5. Nature and extent of the insurer's right to review the premiums payable, and the notice to be given by the insurer in the event of any revision.		
	6. Pre-existing conditions, specified illness and qualifying period and the relevant period applicable.		
	7. For yearly renewable policies, whether policy renewal is guaranteed and the maximum possible increase in premium rates expected on policy renewals.		
	8. Conditions that would lead to the following scenarios on policy renewals:		
	• A policy is renewed with a level premium;		
	• A policy is renewed with an increase premium; or		
	• A policy is not renewed.		
	9. Likely implications of switching policy from one insurer to another or transferring from one type of Medical and Health Insurance plan to another.		
	10. A "free-look period" / "cooling-off period" of 15 days will be given to me to review the suitability of the newly-purchased Medical and Health product. If I return the policy to the insurer during this period, the full premiums would be refunded to me minus the deduction for medical expenses incurred by the company on the issue of the policy.		

I acknowledge that I understand the information disclosed to me and I am aware that the details of the important features of the policy are available on the website of the insurer/policy document/etc.

Signature of Proposer : _____ Date : _____

Name of Proposer : _____

Signature of Intermediary : _____ Date : _____

Name, Business Address & Contact No. of Intermediary : _____

Note: *The checklist must be retained by the insurer/intermediary until the expiry of the policy.*

MARKETING AND CONSENT TO TRANSFER ABROAD

Liberty General Insurance Berhad strives to introduce new products and improve services in your best interests. The Personal data may be used by the Liberty General Insurance Berhad and their agents, parent company and/or affiliates (within its financial group) to keep you informed by email, telephone, post or by such other means, of services and/or products and would like to know the best way to keep in touch with you

Yes, I wish to be contacted via:

E-mail ☐ **Telephone** ☐ **Post** ☐

No, I do not wish to be contacted for such purpose. ☐

In certain cases, Liberty General Insurance Berhad may also share limited personal data with third parties outside its financial group for marketing purposes and may also transfer abroad the personal data to entities outside Malaysia who may act on behalf of Liberty General Insurance Berhad and /or any member of the Liberty Mutual Group of Companies provided always that you have expressly consented to our doing so. Please indicate below if you consent to such disclosure.

I agree to Liberty General Insurance Berhad disclosing my information to third parties outside its financial group for marketing purposes and to transfer abroad of my Personal Data.

Yes ☐ **No** ☐

ACKNOWLEDGEMENT AND CONSENT

I hereby confirm that I have read, understood and agree to be bound by the terms of the Liberty General Insurance Berhad Privacy Notice (which is available at www.libertyinsurance.com.my or has been made available to me) and consent to the processing of my Personal data as described in the Liberty General Insurance Berhad Privacy Notice and this Proposal Form above.

Full name : ..... **Signature** : .....

Date : ..... **NRIC** : .....

FOR OFFICE USE ONLY

Official Receipt No:_____ Premium Amount:_____

PERIOD OF COVER

From: _____ To: _____

FOR OFFICE USE ONLY – VERIFICATION OF IDENTITY

In compliance with Section 66(B) and 66(D) of the Anti-Money Laundering, Anti-Terrorism Financing and Proceeds of Unlawful Activities Act 2001

I hereby declare that the Proposer's detail had been verified against the following original documents:

Please tick (√) as appropriate.

☐ National Registration Identity Card (NRIC) ☐ Passport.

☐ Certificate of Registration. ☐ Others (please specify) _____

Full name : _____ Signature : _____

Date : _____ NRIC Number : _____

IMPORTANT NOTE (2)

1. The following persons are authorised to verify the above details
   - Staff of Liberty General Insurance Berhad as authorized by the Company
   - Registered agents of Liberty General Insurance Berhad
2. Copies of documents verified for the following insurance policies must be retained
   - Policies with premiums exceeding RM25, 000 per annum in respect of single policies issued to individuals institutions.
   - Policies with premiums exceeding RM100, 000 per annum in respect of group policies.

IMPORTANT NOTE (3)

Pursuant to the Anti-Money Laundering and Anti-Terrorism Financing (Declaration of Specified Entities and Reporting Requirement) Order 2014 which is issued under Section 66B and 66D of the AMLATFA, all institutions are required to:

- Freeze without delay all property owned, undertaking owned or controlled directly or indirectly by the specified entity; and/or
- Reject or block any transaction by the specified entity.