eTiQa Life Insurance

FOR REVIVAL OF INVESTMENT–LINKED POLICY
(Mandatory to tick **one** box below)

☐ Reinstatement

☐ Activation

☐ Activation with premium holiday repayment*

HEALTH DECLARATION

Policy No. : _____	**Have you made any payment with this application?** **(Yes / No) and amount (if any) RM**_____

IMPORTANT NOTICE

1. In accordance with the requirements of Paragraph 5 of Schedule 9 of the Financial Services Act 2013, you must answer all questions and make the required declarations in this application and these answers and declarations must be accurate and complete.
2. You must notify Etiqa Life Insurance in writing should there be a change to any answers or declarations in this application prior to the date of reinstatement/variation of the policy.
3. Acceptance of your application shall be subject to underwriting assessment. Cover will commence once contract is reinstated or varied.
4. In this application form, unless stated otherwise, the words "I/we, you/your, me/us and my/our" means Policy Owner/Life Insured wherever applicable.
5. Any changes must be signed by Life Assured and Policy Owner.
6. A copy of the completed application with date of submission to Etiqa is **COMPULSORY** to be provided to Policy Owner.
7. *****Activation with premium holiday repayment is not allowed if policy had been revived via reinstatement option prior to this.

A. PERSONAL PARTICULARS	**LIFE ASSURED**	**POLICY OWNER**
Full Name (as stated in I.C.)		
Occupation (Exact Duties) : Nature of Business :	_____ _____	_____ _____
Height & Weight	☐☐☐ CM ☐☐ KG	☐☐☐ CM ☐☐ KG

B. HEALTH DETAILS (Please tick √ 'YES' or 'NO') **If any answer to the below stated question is YES, please state question number and provide details in column C.**	**Life Assured**		**Policy Owner**	
	Yes	**No**	**Yes**	**No**
1. Do you smoke? If yes, how many sticks per day and how long have you been smoking? Life Assured : _____sticks / day for _____year(s) Policy Owner : _____sticks / day for _____year(s)	☐	☐	☐	☐
2. Have you ever had, been diagnosed, or been treated, with an illness / disease / disorder / condition, directly or indirectly related to the following:				
a. Cancer, tumor, cyst, abnormal lump/growth/swelling, leukemia, melanoma or lymphoma	☐	☐	☐	☐
b. Heart, blood vessels, lymph, lymph glands (including coronary artery disease, heart attack, heart murmur, hypertension, high cholesterol, stroke)	☐	☐	☐	☐
c. Blood (including anemia, thalassemia, low platelet count, bleeding problems or any other blood disorder)	☐	☐	☐	☐
d. Lungs (including pneumonia, tuberculosis)	☐	☐	☐	☐
e. Gall bladder, liver, stomach, esophagus, bowel (including hepatitis B or C, blood in the stools, colitis, Crohn's disease)	☐	☐	☐	☐
f. Brain, nerves (including epilepsy, convulsions, seizures, fits, Parkinson's disease, multiple sclerosis, Alzheimer's disease, paralysis, involuntary tremors, psychiatric illness, dementia)	☐	☐	☐	☐
g. Thyroid, pancreas, and endocrine glands (including diabetes, goiter, pancreatitis, hormone disorders)	☐	☐	☐	☐
h. Muscles, bones, joints (including gout, arthritis, rheumatism, prolapsed intervertebral disc, physical abnormality, physical dismemberment or disability)	☐	☐	☐	☐
i. Kidneys, bladder, urinary tract (including blood in the urine, abnormal levels of sugar or protein in urine, kidney stones, and for males, the prostate)	☐	☐	☐	☐
j. Immune system (including SLE - Systemic Lupus Erythematosus)	☐	☐	☐	☐
k. HIV, AIDS, sexually transmitted disease (including herpes, syphilis)	☐	☐	☐	☐
l. For males: prostate disease	☐	☐	☐	☐
m. For females: breast, cervix, uterus, ovaries (including breast lump, carcinoma in situ, breast or ovarian cyst, fibroid)	☐	☐	☐	☐
3. In the past 5 years have you ever had or been advised to have or do you intend to undergo any investigations/screening test including blood/urine tests?	☐	☐	☐	☐
4. Are you currently receiving/considering to seek any medical treatment/advise or in the past 5 years have you ever been referred to or admitted to a hospital or medical facility or ever undergone/been advised to undergo a surgery?	☐	☐	☐	☐

Policy No. : _____	Life Assured		Policy Owner	
	Yes	No	Yes	No
5. Have any of your natural parents and/or siblings, ever suffered from or died as a result of diabetes, cancer, kidney disease, stroke or any other hereditary disease before the age of sixty (60) years? If yes, please provide details of diagnosis, age of onset, current age if living, or age deceased.	☐	☐	☐	☐
6. Have you ever had an application, renewal or reinstatement of a Life Policy or Family Takaful contract, declined, postponed, rated or subject to special terms?	☐	☐	☐	☐
7. Do you have any medical, health or Life policy or Family Takaful certificate with us or any other Insurance company/Takaful operator? If `YES', please provide the company's name, date of issue, plan's name and sum assured of insurance/takaful coverage for all infoce policies or certificates and pending applications in section C. below.	☐	☐	☐	☐

C. If any answer to the above stated question is YES, please state question number and provide details below.

LIFE INSURED	POLICY OWNER

DECLARATION & AUTHORISATION

Please read carefully before signing this application.

1. I/we am/are aware that I/we must answer all questions and declarations in this application, and that these answers and declarations are accurate and complete. I/we agree that failure to answer a question or declaration, or incorrectly answering a question or declaration, may result in termination of the policy, a claim not being paid, or the terms and conditions of the policy being changed.
2. I/we agree to notify Etiqa Life Insurance in writing should there be a change to any answers or declarations in this health declaration Form, prior to the date of reinstatement/variation of the policy. I/we agree that failure to notify Etiqa Life Insurance of any such change, may result in termination of the policy, a claim not being paid, or the terms and conditions of the policy being changed.
3. I/We confirm that I/we fully understand that my/our answers and/or statements given in this application and any other relevant documents completed by me/us in connection with this application and in any medical report, questionnaires or amendments thereto shall be an integral part of the contract and that Etiqa Life Insurance will completely rely on them in deciding whether to accept my/our application or not.
4. I/We hereby authorise any physician, hospital, clinic, insurance company/Takaful operator, financial institution or any other organization or company or person that has any records or knowledge about me/us, my/our financial standing or my/our health, to disclose to Etiqa Life Insurance or its representatives any or all information about me/us with reference to my/our family history and/or my/our financial standing and/or medical history before or after my/our death. I/We agree that a photocopy or facsimile of this authorisation shall be considered as effective and valid as the original and legally binding on anyone who takes over any of my/our legal rights.
5. I/We understand and agree that the insurance coverage I/we have applied for shall only take effect on the date of the POLICY CONTRACT HAS BEEN REINSTATED OR VARIED by Etiqa Life Insurance provided always that this application has been approved and that the full payment premium has been received by Etiqa Life Insurance during my/our lifetime and that prior to or as at the date of commencement of the cover, there has been no alterations as to my/our health. If the premium is paid via cheque, I/we understand that the insurance coverage will only commence after the cheque has been cleared.
6. **For Investment-Linked policy only**
   I/We hereby understand and agree that the transaction(s) of unit(s) shall be determined by the valuation of the unit price as of the Acceptance Date, and subject to the receipt of this application by the Etiqa Head Office on its business and by 1pm day ("Day received"), otherwise the Acceptance Date shall mean the next business day from the Day Received. I/We also understand that Etiqa shall only accept and process this application if all required information(s) and document(s) have been fully satisfied.

   ☐ I hereby acknowledge that I have read and understood the explanation regarding my policy sustainability which will be or will not be impacted as per the quotation number _____ if I proceed to perform the transaction that has been selected.

Signed on this day : _____/ _____/ _____(DD / MM / YYYY)

Signature of Life Assured	Signature of Policy Owner	Signature of Witness *
Name :	Name :	Name :
ID No. :	ID No. :	ID No. :
Mobile No. :	Mobile No :	Mobile No :
Address :	Address :	Address :

*** STATEMENT OF WITNESS:** I hereby certify that all signature in this form was made in my presence and that to my best knowledge it is the signature of the Policy Owner/ Life Assured under the policy.

Note: Witness must be at least 18 years of age, of sound mind and cannot be the named nominee or trustee.

For Office Use Only	Date & Time Received at MBB / Branch	DD/MM/YYYY HH:SS AM/PM MANDATORY FOR INVESTMENT-LINKED

Etiqa Life Insurance Berhad (201701025113)
(Dilesenkan di bawah Akta Perkhidmatan Kewangan 2013 dan dikawal selia oleh Bank Negara Malaysia)
Dataran Maybank, No. 1, Jalan Maarof, 59000 Kuala Lumpur
T +603 2297 3888 F +603 2297 3800 E info@etiqa.com.my www.etiqa.com.my
Etiqa Oneline 1300 13 8888
Ahli Kumpulan Maybank