HEALTH DECLARATION

Certificate No :	**Have you made any payment with this application? (Yes / No) and amount if any RM** _____ (Inclusive of `GST', if any)
☐☐☐☐☐☐☐☐☐☐☐☐ - ☐	

Important Notice:

1. In accordance with the requirements of Paragraph 5 of Schedule 9 of the Islamic 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 Family Takaful Berhad in writing should there be a change to any answers or declarations in this application prior to the date of reinstatement/variation of the certificate.
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 Certificate Owner/Person Covered wherever applicable.

A. PERSONAL PARTICULARS	**PERSON COVERED**	**CERTIFICATE OWNER**
Full Name (as stated in I.C.)		
Occupation (Exact Duties) : Industry :	_____ _____	_____ _____
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.**	**PERSON COVERED**		**CERTIFICATE OWNER**	
	Yes	**No**	**Yes**	**No**
1. Do you smoke? If yes, how many sticks per day and how long have you been smoking? Person Covered : _____sticks / day for _____year(s) Certificate 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)	☐	☐	☐	☐

AABCBABBALPS26

Certificate No : | | | | | | | | | | | | | - | |

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?	☐	☐	☐	☐
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. If you have any medical, health or life policy or Family Takaful contracts, with us or any other insurance/Takaful company? If yes, please provide details of all inforce policies/contracts and pending applications. If `YES', please provide the company's name, date of issue and sum assured of insurance/Takaful coverage in column C.	☐	☐	☐	☐

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

PERSON COVERED	CERTIFICATE 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 certificate, a claim not being paid, or the terms and conditions of the certificate being changed.

2. I/we agree to notify Etiqa Family Takaful Berhad in writing should there be a change to any answers or declarations in this health declaration Form, prior to the date of issuance/reinstatement/variation of the certificate. I/we agree that failure to notify Etiqa Family Takaful Berhad of any such change, may result in termination of the certificate, a claim not being paid, or the terms and conditions of the certificate 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 Family Takaful Berhad 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 Family Takaful Berhad 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 Takaful coverage I/we have applied for shall only take effect on the date of the CERTIFICATE CONTRACT HAS BEEN REINSTATED OR VARIED by Etiqa Family Takaful Berhad provided always that this application has been approved and that the full payment contribution has been received by Etiqa Family Takaful Berhad 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 contribution is paid via cheque, I/we understand that the protection coverage will only commence after the cheque has been cleared.

Signed on this day : _____/ _____/ 20 _____ (DD / MM / YYYY)

Signature of Person Covered	Signature of Certificate Owner	Signature of Witness
Name :	Nama :	Nama :
ID. No. :	No KP :	No KP :
Tel. No. :	No. Tel :	No. Tel :
Address :	Alamat :	Alamat :

***Witness must be at least 18 years of age, of sound mind and cannot be the named nominee.**

Note: Any changes must be signed by Person Covered and Certificate Owner.

Etiqa Family Takaful Berhad (266243D)
(Formerly known as Etiqa Takaful Berhad)
(Licensed under Islamic Financial Services Act 2013 and regulated by 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