

Family Takaful

or ovarian cyst, fibroid)

Have you made any nayment with this application?	
Activation inclusive contribution holiday amount	
Activation	
Reinstatement	
FOR REVIVAL OF INVESTMENT-LINKED CERTIFICATE (Mandatory to tick one box below)	

г атпу такатиг		Activation	l									
HEALTH DECLARATION		Activation	n inclusive con	tribution	n holiday	amoun	t					
Certificate No :	Have	vou made	any payment	with thi	is appli	cation?						
	(Yes / No) and amount if any											
IMPORTANT NOTICE												
 In accordance with the requirements of Paragraph 5 of make the required declarations in this application and the 2 You must notify Etiqa Family Takaful Berhad in writing reinstatement/variation of the certificate. Acceptance of your application shall be subject to under 4 In this application form, unless stated otherwise, the applicable. Any changes must be signed by Person Covered and Pa 6 A copy of the completed application with date of submis. 	ese answers and declara should there be a chang writing assessment. Cov words "I/we, you/you articipant sion to Etiqa is COMPU	ations must be ge to any answ ver will comme r, me/us and	e accurate and cor vers or declaration ence once contrac my/our" means	nplete. s in this a t is reinsta Participar ipant.	application ated or var nt/Person	prior to the decirion of the d	ne date of					
	ERSON COVERED			PAR1	ICIPAN	T						
Full Name (as stated in I.C.)												
Occupation (Exact Duties) :												
Industry:												
Height & Weight	cm	kg		cn	n		kg					
B. HEALTH DETAILS (Please tick √ 'YES' or 'NO') If any answer to the below stated question is YES,					SON ERED	PARTICIPANT						
please state question number and provide		ı C.		Yes	No	Yes	No					
1. Do you smoke? If yes, how many sticks per day and how long hav Person Covered : sticks / day for _ Certificate Owner : sticks / day for _	e you been smoking? year(s) year(s)											
2. Have you ever had, been diagnosed, or been treadirectly or indirectly related to the following:a. Cancer, tumor, cyst, abnormal lump/growth/swb. Heart, blood vessels, lymph, lymph glands (in	elling, leukemia, mela	inoma or lym	phoma									
heart murmur, hypertension, high cholesterol, stroke) c. Blood (including anemia, thalassemia, low platelet count, bleeding problems or any other 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)												
 Kidneys, bladder, urinary tract (including blooprotein in urine, kidney stones, and for males, t 	of sugar or											
j. Immune system (including SLE - Systemic Lupus Erythematosus)												
k. HIV, AIDS, sexually transmitted disease (including herpes, syphilis)												
I. For males: prostate disease												
m. For females: breast, cervix, uterus, ovaries (including breast lump, carcinoma in situ, breast												

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Certificate No :			PERSON COVERED		PARTICIPANT				
			Yes No		Yes 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		eatment/advise or in the past 5							
years 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 s	=								
cancer, kidney disease, stroke or any other hereditary disease before the age of sixty (60) If yes, please provide details of diagnosis, age of onset, current age if living, or age deceased.									
6. Have you ever had an application, renev	wal or reinstatement of	f a Life Policy or Family Takaful							
certificate, declined, postponed, rated or	<u> </u>								
7. If you have any medical, health or life Po	olicy or Family Takaful	certificate, with us or any other							
certificates and pending applications. If	insurance company or Takaful operator? If yes, please provide details of all inforce policies or certificates and pending applications. If `YES', please provide the company's name, date of plan's name and sum assured of insurance/Takaful coverage in column C.								
C. If any answer to the above stated	·				ils belo	w.			
PERSON COVEREI	0	PAR	TICIPAN	T					
DECLARATION & AUTHORISATION									
Please read carefully before signing this application		o in this application, and that these ap	awara and .	docloration	0 0ro 000	urata and			
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 Berl	~	-							
prior to the date of 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 certificate 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 HAS BEEN REINSTATED OR VARIED by Etiqa Family Takaful Berhad provided always that this application has been approved and that the full payment of 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									
there has been no alterations as to my/our commence after the cheque has been cleared		n is paid via cheque, I/we understand	that the	protection	coverage	will only			
6. For investment sustainability 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 day and by 1pm ("Day received"),otherwise the Acceptance 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 certificate 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 Person Covered	Signature of Participant	Signature of V	Witness						
Name :	Name :	Name	:						
ID. No. :	ID. No. :	ID. No.	:						
Tel. No. :	Tel. No. : Address :	Tel. No. Address	:						
For Office Use Only Date & Time Received	at MBB/ Branch (MANDA	ATORY FOR INVESTMENT LINKED)							