

Child 1

Name in Block Letters (as in NRIC/Passport):

Gender: Male Female

Birth Certificate/NRIC/Passport No.:

Date of Birth: _____ (dd-mm-yyyy)

Is this child a full time student in Malaysia? Yes No

Height: _____ cm

Weight: _____ kg

Age Next Birthday: _____

Child 2

Name in Block Letters (as in NRIC/Passport):

Gender: Male Female

Birth Certificate/NRIC/Passport No.:

Date of Birth: _____ (dd-mm-yyyy)

Is this child a full time student in Malaysia? Yes No

Height: _____ cm

Weight: _____ kg

Age Next Birthday: _____

Child 3

Name in Block Letters (as in NRIC/Passport):

Gender: Male Female

Birth Certificate/NRIC/Passport No.:

Date of Birth: _____ (dd-mm-yyyy)

Is this child a full time student in Malaysia? Yes No

Height: _____ cm

Weight: _____ kg

Age Next Birthday: _____

PART IV. DETAILS OF INSURANCE

Product: SmartCare Optimum SmartCare Executive Others, please specify: _____

Optional Deductible (applicable to **SmartCare Optimum** only)

Premium Discount (Deductible): 25% (RM7,500) 30% (RM10,000) 40% (RM15,000) 50% (RM20,000)

Persons To Be Insured	Plan	Annual Premium
Self		
Spouse		
Children		

Annual Premium: RM _____

Add Occupation Loading (if any): RM _____

Add 5% Service Tax (for Group Policy Only): RM _____

Add RM10.00 Stamp Duty: RM _____

Total Amount Due: RM _____

PART V. QUESTIONNAIRE

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Has any one of the Applicants proposed for Insurance hereunder been suffering from or receiving medical advice, counselling or treatment, in connection with: | | |
| (a) any disease of the brain, nervous breakdown, fits, anxiety, mental or nervous disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) any lung trouble, eg. asthma, spitting of blood, tuberculosis, bronchitis, pneumonia? | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) any heart trouble, stroke, rheumatic fever, chest pain, shortness of breath or circulatory disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) any stomach, bowel, kidney or bladder trouble? | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) any form of rheumatism, arthritis or back trouble? | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) any enlarged glands or any form of cancer, tumor or disorder of the blood? | <input type="checkbox"/> | <input type="checkbox"/> |
| (g) any condition requiring treatment (eg. raised blood pressure, diabetes) or used medication for any other reason? | <input type="checkbox"/> | <input type="checkbox"/> |
| (h) any eyes, ear, nose or throat trouble? | <input type="checkbox"/> | <input type="checkbox"/> |
| (i) any allergy to food, plants, pollen, dust, medicines, animals, etc? | <input type="checkbox"/> | <input type="checkbox"/> |
| (j) any observation, medical or surgical advice, diagnostic test, hospital confinement, investigation, or treatment that has not been performed or completed otherwise than as already stated? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does any one of the Applicants proposed for Insurance hereunder: | | |
| (a) suffered from or presently has any physical defect, infirmity or congenital conditions? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) ever been declined or restricted or accepted on special terms on other medical insurance plans? | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) has other health insurance currently in force with any companies? (If 'Yes', please attach a copy of the existing policy contract) | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) has ever made any claims from other insurance companies? | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) has ever carried out medical check-up or blood tests in the past 5 years? (If 'Yes', please attach a copy of the report) | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) currently under observation or taking any medication or treatment or aware of any signs or symptoms which may indicate a medical disorder or poor health? | <input type="checkbox"/> | <input type="checkbox"/> |

Name of Proposer: _____

