

| | YES | NO |
|---|-----|----|
| 1. Does the person to be insured have Health Insurance with us or any other company? If 'Yes', please attach a copy of the existing Policy Schedule. | | |
| 2. Has the person to be insured: | | |
| a. Suffered or have any physical defect, infirmity or congenital conditions? | | |
| b. Had any medical check-up, x-ray scan, blood test, urine test, ECG or currently under observation or receiving treatment or taking any medication? If yes, please provide us with copies of the results. | | |
| c. Undergone any surgical operation or suffered any disease or injury? | | |
| d. Ever been advised to have a surgical operation which has not been performed? | | |
| 3. Have you or any of the persons to be insured ever been told that you or they suffered from or had been treated for any of the following: | | |
| a. Chronic cough, spitting of blood, asthma, hay fever, pleurisy, tuberculosis or any other disease of the respiratory system? | | |
| b. High or low blood pressure, heart disease, chest pain, heart attack, shortness of breath, palpitation or heart disorder? | | |
| c. Epilepsy, fits, dizziness, mental or nervous disorder? | | |
| d. Diabetes, sugar or blood in urine, kidney, colic or hernia? | | |
| e. Disease of the eyes, ears, nose or throat? | | |
| f. Arthritis, sciatica, rheumatism, back, spine, bone, joint, muscle or skin disorder? | | |
| g. Ulcer or disorder of the stomach, intestines, haemorrhoids or rectal disorder? | | |
| h. Gall bladder stone or liver disease or any type of hepatitis? | | |
| i. Cancer, tumour or growth of any kind in any organ system? | | |
| j. Anaemia, Thyroid disorder (such as Goitre) or Rheumatic Fever? | | |
| k. Sexually transmitted diseases such as syphilis, gonorrhoea or non-specific urethritis? | | |
| l. AIDS or AIDS-related conditions? | | |
| m. Any illness, disease or injury not mentioned above? | | |
| 4. Have any of your parents or sibling ever had or died from cancer including breast cancer, tuberculosis, diabetes, hypertension, stroke, kidney disease, heart disease, multiple sclerosis, mental illness or any other hereditary disease or any AIDS related condition? | | |

5. If any of the answers is 'Yes' to questions 2, 3 & 4 please give details below and number your answers to correspond with the number of the questions to which the answer applies:

| | |
|--|--|
| Question No. | |
| Name Of person | |
| Type and Date of Disability | |
| Current Status of Disability | |
| Name and Address of Hospital and Physician | |

| | |
|--|--|
| Question No. | |
| Name Of person | |
| Type and Date of Disability | |
| Current Status of Disability | |
| Name and Address of Hospital and Physician | |

| | |
|--|--|
| Question No. | |
| Name Of person | |
| Type and Date of Disability | |
| Current Status of Disability | |
| Name and Address of Hospital and Physician | |

6. Has the person to be insured's application for any medical or hospitalisation type of policy ever been declined, restricted or accepted at other than normal terms.

YES

NO

If Yes, please state reason and provide the name of the Insurance Company.

7. Blood Type _____

Allergies _____

| | Age | Plan No. | Premium (RM) |
|-----------|-----|----------|--------------|
| Proposer | | | |
| Spouse | | | |
| 1st Child | | | |
| 2nd Child | | | |
| 3rd Child | | | |

Sub Total RM _____

less 12% Family Discount* RM (_____)

add Stamp Duty RM 10.00

Total Payable RM _____

* Note: Family Discount is available only if 3 or more family members apply

PRODUCT DISCLOSURE INFORMATION

Please read this Product Disclosure information before you decide to take out the [Sihat Malaysia](#) plan.

You are advised to refer to the policy document for full details of the product terms and conditions, including those outlined below.

If you are in doubt, please seek clarification from your agent or contact our Call Centre at 1-300-80-8800.

(A) Contractual rights and obligations

- 1) If the proposal/declaration of the Policyholder or Insured Person is untrue or misrepresented/misstated in any respect, including but not limited to the Insured Person's age, medical condition, occupation, height, weight, smoking and alcohol consumption details, then the company will repudiate liability of a claim and void the Policy.
- 2) You are to ensure that this Proposal/Application form is completed accurately as it forms the basis of the insurance contract.
- 3) The period of coverage will be for one year.
- 4) This is a Hospital & Surgical (H & S) Policy until age 70.
It is a yearly Renewable Policy which means, the policy is renewable at the option of the Company. This Policy shall become effective as of the date stated in the Policy Schedule. The Policy Anniversary shall be one year after the effective date and annually thereafter. On each such anniversary, this Policy is renewable at the premium rates in effect at that time as notified by the Company. This Policy is renewable at the option of the Company. Application for change of benefits to a higher plan can only be made on renewal and is subject to acceptance by the Company upon renewal.
- 5) If the Insured Person is hospitalized at a published Room & Board rate which is higher than his/her eligible benefit, the Insured Person shall bear 20% of the other eligible benefits described in the Schedule of Benefits.
- 6) You are advised to ensure you receive and keep the receipt of payment from the company as proof of payment of premiums.
- 7) Your policy will be issued and passed to your agent within fourteen (14) days from receipt of full documentation, medical reports and any other underwriting requirements.

(B) Cooling-Off Period

Cooling-Off Period may apply if this Policy shall have been issued and for any reason whatsoever the Insured Person shall decide not to take up the Policy, the Insured Person may return the Policy to the Company for cancellation provided such request for cancellation is delivered by the Insured Person to the Company within fifteen (15) days from the date of delivery of the Policy. The Insured Person is entitled to the return of the full premium paid less deduction of medical expenses incurred by the Company in the issue of the Policy.

(C) Replacement of policies

The implications of switching policy from one insurer to another or transferring from one insurance plan to another that may cause the Waiting Period, Specific Illness and Pre-existing Conditions to start afresh or non acceptance of your proposal.

(D) Renewal premium

The renewal premium payable for the H & S Policy is not guaranteed;

- a) The Company can revise the premium at the time of renewal according to the Company's risk assessment.
- b) The premium rate is age-banded and is payable according to each member's age on each Policy year anniversary.

(E) Claims Procedure

- a) The Insured Person shall within 30 days of a Disability that incurs claimable expenses, give written notice to the Company stating full particulars of such event, including all original bills and receipts, and a full Physician's report stipulating the diagnosis of the condition treated and the date the Disability commenced in the Physician's opinion and the Physician's summary of the cost of treatment including medicines and services rendered. Failure to furnish such notice within the time allowed shall not invalidate any claim if it is shown not to have been reasonably possible to furnish such notice and that such notice was furnished as soon as was reasonably possible.
- b) The Insured Person shall immediately procure and act on proper medical advice and the Company shall not be held liable in the event a treatment or service becomes necessary due to failure of the Insured Person to do so.

(F) Notice of cancellation

This Policy may be cancelled by the Policyholder at any time by giving a written notice to the Company; and provided that no claims have been made during the current policy year, the Policyholder shall be entitled to a refund of the premium as follow:-

| Period Not Exceeding | Refund of Annual Premium |
|----------------------------|----------------------------------|
| 15 days | 90% (applicable to renewal only) |
| 1 month | 80% |
| 2 months | 70% |
| 3 months | 60% |
| 4 months | 50% |
| 5 months | 40% |
| 6 months | 30% |
| 7 months | 25% |
| 8 months | 20% |
| 9 months | 15% |
| 10 months | 10% |
| 11 months | 5% |
| Period Exceeding 11 Months | No Refund |

(G) Change of contact details

It is important that you inform the Company of any change in your contact details to ensure all correspondences reach you in a timely manner.

(H) Major Benefits and indicative premium rates*

| PLANS | PLAN 1 | PLAN 2 | PLAN 3 | PLAN 4 | PLAN 5 | PLAN 6 |
|---|--|--------|--------|--------|---------|---------|
| BENEFITS | RM | RM | RM | RM | RM | RM |
| ANNUAL LIMIT | | | | | | |
| • Overall Annual Limit | 10,000 | 20,000 | 30,000 | 50,000 | 100,000 | 150,000 |
| MAXIMUM PER DISABILITY | | | | | | |
| HOSPITAL BENEFITS | | | | | | |
| • Hospital Room & Board (Max. 150 days) | 60 | 80 | 120 | 200 | 350 | 450 |
| • Intensive Care Unit (Max. 75 days) | 120 | 160 | 250 | 400 | 500 | 600 |
| • Hospital Supplies & Services | • As Charged (Subject to Reasonable and Customary Charges) • | | | | | |
| • Operating Theatre | | | | | | |
| SURGICAL BENEFITS | | | | | | |
| Surgical expenses comprising the following, but excluding organ transplantation | | | | | | |
| • Pre-Surgical Diagnostic Tests (Within 60 days prior to surgery) | 7,000 | 12,000 | 20,000 | 30,000 | 65,000 | 100,000 |
| • Pre-Surgical Specialist Consultation (Within 60 days prior to surgery) | | | | | | |
| • Surgical Fees | | | | | | |
| • Anaesthetist Fees | | | | | | |
| MEDICAL BENEFITS | | | | | | |
| Medical expenses for non-surgical treatment, comprising | | | | | | |
| • Pre-Hospital Diagnostic Tests (Within 60 days prior to admission) | 7,000 | 12,000 | 20,000 | 30,000 | 65,000 | 100,000 |
| • Pre-Hospital Specialist Consultation (Within 60 days prior to admission) | | | | | | |
| • In-Hospital Physician Visit (Max. 60 days) | | | | | | |
| • Post-Hospitalisation Treatment (Within 31 days from discharge) | | | | | | |
| OUT-PATIENT BENEFITS | | | | | | |
| • Emergency Accidental Out-Patient Treatment (Within 24 hours and follow-up treatment to a max. of 31 days) | • As Charged (Subject to Reasonable and Customary Charges) • | | | | | |
| • Out-Patient Physiotherapy Treatment (Within 90 days from discharge / surgery) | | | | | | |
| • Ambulance Fees | 200 | 250 | 300 | 500 | 700 | 1,000 |
| • Monthly Out-Patient Kidney Dialysis & Cancer Treatment | 1,000 | 2,000 | 3,500 | 4,000 | 5,000 | 6,000 |
| ORGAN TRANSPLANT | | | | | | |
| • Heart, Kidney, Lung, Liver or Bone Marrow Transplantation | 5,000 | 12,500 | 20,000 | 30,000 | 50,000 | 60,000 |
| OTHER BENEFITS | | | | | | |
| • Daily Cash Allowance at Government Hospital (Max. 150 days) | 25 | 35 | 45 | 50 | 55 | 60 |
| • Insured Child's Daily Guardian Benefit (Max. 60 days) | 25 | 50 | 75 | 100 | 175 | 200 |
| ANNUAL PREMIUM (age next birthday) | | | | | | |
| AGE BAND* | | | | | | |
| 30 days - 17 years | 243 | 319 | 405 | 491 | 621 | 758 |
| 18 - 35 years | 248 | 336 | 411 | 493 | 641 | 754 |
| 36 - 45 years | 305 | 415 | 499 | 596 | 767 | 892 |
| 46 - 55 years | 433 | 595 | 713 | 854 | 1,098 | 1,285 |
| 56 - 60 years | 600 | 844 | 1,025 | 1,243 | 1,644 | 1,959 |
| 61 - 65 years (renewal only) | 746 | 1,101 | 1,358 | 1,690 | 2,361 | 2,854 |
| 66 - 70 years (renewal only) | 849 | 1,285 | 1,630 | 2,056 | 2,989 | 3,675 |

The actual terms and conditions will be in the original policy to be delivered to you once the Company has underwritten and approved your proposal.

The above essential information has been satisfactorily explained to me.

.....
Name of Applicant NRIC No. Signature Date

DECLARATION BY AGENT

I declare and confirm that:

- (A) All information contained in this proposal is the only information given to me by the applicant and/or the life to be insured, and I have not withheld any other information which might influence the acceptance of this proposal.
- (B) I have not given any statement to the applicant and/or the life to be insured contrary to the provisions as contained in the Company's standard policy.
- (C) I have sighted the original NRIC and verified the identity of the applicant through the use of NRIC or other documents.

| | |
|--------------------------------|---|
| _____ Signature of Agent | _____ Name of Agent (In Block Letters) |
| _____ Place | _____ Date |
| Date received at Branch Office | Date received at Head Office |

Special Notification: The applicant is hereby notified that the Company has appointed agents/representatives who have the authority to solicit or negotiate contracts of insurance on behalf of the Company. All authorised agents / representatives are issued with authorisation cards.

THIRD PARTY VERIFICATION

In compliance with Section 16(2) of the Anti-Money Laundering Act 2001, I hereby certify that the Proposer's original new NRIC / Business Registration Certificate was verified and authenticated by me at the point of sales.

| | |
|---------------------------|----------------------|
| _____ Signature | _____ Name |
| _____ NRIC No. | _____ Date |

"Third Party" means insurance agents, insurance brokers or staff of insurance companies.

Note : A copy of the proposer's new NRIC/ Business Registration Certificate must be submitted together with this declaration for individual insurance policy with premium exceeds RM50,000.00

| | YA | TIDAK |
|--|----|-------|
| 1. Adakah anda atau sesiapa yang akan diinsuranskan memiliki Insurans Perubatan dengan kami atau syarikat lain? Jika "Ya", sila sertakan salinan Jadual Polisi tersebut. | | |
| 2. Pernahkah anda atau sesiapa yang akan diinsuranskan: | | |
| a. Mengalami kecacatan fizikal, keuzuran atau penyakit kongenital? | | |
| b. Pernah melalui pemeriksaan kesihatan, ujian x-ray, ujian darah, ujian air kencing, ECG, atau sedang dalam pemerhatian atau menerima rawatan atau mengambil sebarang ubat-ubatan? Jika ya, sila lampirkan salinan laporan. | | |
| c. Menjalani sebarang pembedahan atau mengalami sebarang penyakit atau kecederaan? | | |
| d. Dinasihatkan menjalani sebarang pembedahan yang belum dilaksanakan? | | |
| 3. Pernahkah anda atau sesiapa yang akan diinsuranskan diberitahu bahawa anda atau mereka mengalami atau pernah menerima rawatan sebarang penyakit di bawah : | | |
| a. Batuk kronik, ludah berdarah, asma, demam alergi, radang pleura, tibi, atau sebarang penyakit sistem pernafasan lain? | | |
| b. Tekanan darah tinggi atau rendah, penyakit jantung, sakit dada, serangan jantung, sesak nafas, palpitasi atau gangguan jantung? | | |
| c. Gila babi, sawan, pening, gangguan mental atau saraf? | | |
| d. Diabetis, kandungan gula dalam darah atau air kencing, penyakit buah pinggang, kolik atau hernia? | | |
| e. Penyakit mata, telinga, hidung atau tekak? | | |
| f. Arthritis, skiatika, reumatisma, penyakit belakang, tulang belakang, tulang, sendi, otot atau kulit? | | |
| g. Ulser atau penyakit dalam perut, usus, buasir, atau rektum? | | |
| h. Batu pundi hempedu, atau penyakit hati atau sebarang jenis hepatitis? | | |
| i. Kanser, tumor atau sebarang ketumbuhan dalam mana-mana sistem organ? | | |
| j. Anemia, penyakit Tiroid (seperti Goiter) atau Demam Reumatik? | | |
| k. Penyakit yang berjangkit melalui seks seperti sifilis, gonorea atau urethritis tidak spesifik? | | |
| l. AIDS atau penyakit berkaitan-AIDS? | | |
| m. Sebarang penyakit atau kecederaan yang tidak disebut di atas? | | |
| 4. Pernahkah ibubapa atau adik-beradik anda mengalami atau meninggal dunia akibat kanser termasuk kanser payu dara, batuk kering, kencing manis, hipertensi, strok, penyakit buah pinggang, penyakit jantung, sklerosis berganda, penyakit mental atau sebarang penyakit keturunan atau sebarang AIDS? | | |

5. Jika jawapan untuk mana-mana soalan 2, 3 & 4 adalah "Ya", sila beri keterangan di bawah dengan mencatatkan nombor jawapan mengikut nombor soalan.

| | |
|--|--|
| No. Soalan | |
| Nama | |
| Jenis dan Tarikh Ketidakupayaan | |
| Status Semasa Ketidakupayaan | |
| Nama dan Alamat Hospital dan Pakar Perubatan | |

| | |
|--|--|
| No. Soalan | |
| Nama | |
| Jenis dan Tarikh Ketidakupayaan | |
| Status Semasa Ketidakupayaan | |
| Nama dan Alamat Hospital dan Pakar Perubatan | |

| | |
|--|--|
| No. Soalan | |
| Nama | |
| Jenis dan Tarikh Ketidakupayaan | |
| Status Semasa Ketidakupayaan | |
| Nama dan Alamat Hospital dan Pakar Perubatan | |

6. Pernahkah permohonan anda atau tanggungan anda untuk polisi perubatan atau hospital ditolak, dihadkan atau diterima dengan syarat-syarat bukan biasa.

YA

TIDAK

Jika Ya, sila nyatakan punca serta nama Syarikat Insurans.

7. Jenis Darah _____

Alahan _____

| | Umur | No. Pelan | Premium (RM) |
|--------------|------|-----------|--------------|
| Pemohon | | | |
| Pasangan | | | |
| Anak Pertama | | | |
| Anak Kedua | | | |
| Anak Ketiga | | | |

Jumlah Kecil RM _____

Kurang 12% Diskaun Keluarga* RM (_____)

Tambah Duti Setem RM 10.00

Jumlah Bayaran Penuh RM _____

* Nota: Diskaun Keluarga tertakluk kepada permohonan sekurang-kurangnya tiga ahli keluarga

Sila baca Maklumat Pendedahan Produk ini sebelum anda mengambil keputusan untuk mengambil pelan [Sihat Malaysia](#).

Anda dinasihatkan supaya merujuk kepada dokumen polisi untuk butir-butir penuh terma dan syarat, termasuk yang dinyatakan di bawah. Jika anda ragu-ragu, sila minta penjelasan daripada ejen anda atau hubungi Pusat Panggilan kami menerusi telefon 1-300-80-8800.

(A) Hak dan kewajipan di bawah kontrak

- 1) Jika cadangan/akuan Pemegang Polisi atau Orang yang Diinsuranskan adalah tidak benar atau silap/disalah nyata dalam apa cara sekalipun, termasuk tetapi tidak terhad kepada butir-butir umur, masalah perubatan, pekerjaan, ketinggian, berat badan, tabiat merokok dan pengambilan alkohol, maka syarikat akan menolak liabiliti tuntutan dan membatalkan Polisi.
- 2) Anda hendaklah memastikan borang Cadangan/Permohonan ini diisi dengan tepat dan lengkap kerana ia membentuk asas kontrak insurans.
- 3) Tempoh perlindungan adalah untuk satu tahun.
- 4) Ini adalah Polisi Hospital & Pembedahan (H & P) hingga umur 70 tahun. Ia adalah Polisi yang perlu diperbaharui setiap tahun, dan ini bermakna Polisi diperbaharui atas pilihan Syarikat. Polisi ini berkuat kuasa dari tarikh yang dinyatakan dalam Jadual Polisi. Ulang tahun Polisi adalah satu tahun selepas tarikh kuat kuasa dan setiap tahun selepas itu. Pada setiap tarikh ulang tahun, Polisi ini boleh diperbaharui dengan kadar premium pada tarikh pembaharuan seperti yang dimaklumkan oleh Syarikat. Polisi ini boleh diperbaharui atas pilihan Syarikat. Permohonan untuk pertukaran manfaat kepada pelan lebih tinggi hanya boleh dibuat semasa pembaharuan dan tertakluk kepada penerimaan Syarikat semasa pembaharuan.
- 5) Jika kadar Bilik & Makanan Orang Yang Diinsuranskan yang dimasukkan ke hospital adalah lebih tinggi daripada manfaat yang layak diperolehinya, Orang Yang Diinsuranskan hendaklah menanggung 20% daripada manfaat layak lain yang dinyatakan dalam Jadual Manfaat.
- 6) Anda dinasihatkan supaya memastikan anda menerima dan menyimpan resit bayaran daripada syarikat sebagai bukti pembayaran premium.
- 7) Polisi anda akan dikeluarkan dan diserahkan kepada ejen anda dalam masa empat belas (14) hari dari tarikh penerimaan dokumen penuh, laporan perubatan dan sebarang keperluan taja jamin lain.

(B) Tempoh Bertenang

Tempoh Bertenang boleh diguna pakai jika Polisi ini telah dikeluarkan dan atas apa jua sebab Orang Yang Diinsuranskan mengambil keputusan untuk tidak menerima Polisi, Orang Yang Diinsuranskan boleh memulangkan Polisi kepada Syarikat untuk pembatalan dengan syarat permintaan untuk pembatalan sedemikian diserahkan oleh Orang Yang Diinsuranskan kepada Syarikat dalam masa lima belas (15) hari dari tarikh Polisi dihantar kepadanya. Orang Yang Diinsuranskan layak mendapat bayaran balik premium penuh yang telah dibayar selepas ditolak perbelanjaan perubatan yang ditanggung oleh Syarikat untuk mengeluarkan Polisi.

(C) Penggantian polisi

Pertukaran polisi daripada satu syarikat insurans kepada syarikat insurans lain atau pertukaran daripada satu pelan insurans kepada pelan insurans lain boleh menyebabkan syarat Tempoh Menunggu, Penyakit Tertentu dan Penyakit Sedia Ada dimulakan semula atau cadangan anda tidak diterima.

(D) Pembaharuan premium

Premium pembaharuan yang perlu dibayar untuk Polisi H & P tidak dijamin;

- a) Syarikat boleh menyemak premium pada masa pembaharuan menurut penilaian risiko Syarikat.
- b) Kadar premium adalah terikat kepada umur dan dibayar menurut umur setiap ahli pada setiap ulang tahun Polisi.

(E) Prosedur Tuntutan

- a) Orang Yang Diinsuranskan hendaklah dalam masa 30 hari selepas Kehilangan Upaya yang menimbulkan perbelanjaan boleh dituntut, memberi notis bertulis kepada Syarikat dengan menyatakan butir-butir penuh kejadian sedemikian, termasuk semua bil dan resit asal, dan laporan penuh Pakar Perubatan yang memberikan diagnosis keadaan yang dirawat dan tarikh Kehilangan Upaya bermula pada pendapat Pakar Perubatan dan ringkasan Pakar Perubatan tentang kos rawatan termasuk ubat-ubatan dan perkhidmatan yang diberikan. Kegagalan memberikan notis sedemikian dalam tempoh yang dibenarkan tidak akan membatalkan sebarang tuntutan jika didapati notis sedemikian tidak dapat diberikan atas sebab munasabah dan notis tersebut telah dikemukakan sejurus selepas ia dapat diberikan.
- b) Orang Yang Diinsuranskan hendaklah mendapatkan nasihat perubatan yang betul dan bertindak menurut nasihat perubatan sedemikian dan Syarikat tidak boleh dipertanggungjawabkan sekiranya rawatan dan perkhidmatan perlu diberi disebabkan kegagalan Orang Yang Diinsuranskan untuk berbuat demikian.

(F) Notis pembatalan

Polisi ini boleh dibatalkan oleh Pemegang Polisi pada bila-bila masa dengan memberi notis bertulis kepada Syarikat; dan dengan syarat tiada tuntutan dibuat pada tahun semasa polisi, Pemegang Polisi berhak mendapat pembayaran balik premium sebagaimana berikut:-

| Tempoh Tidak Melebihi | Bayaran Balik Premium Tahunan |
|--------------------------|--------------------------------|
| 15 hari | 90% (untuk pembaharuan sahaja) |
| 1 bulan | 80% |
| 2 bulan | 70% |
| 3 bulan | 60% |
| 4 bulan | 50% |
| 5 bulan | 40% |
| 6 bulan | 30% |
| 7 bulan | 25% |
| 8 bulan | 20% |
| 9 bulan | 15% |
| 10 bulan | 10% |
| 11 bulan | 5% |
| Tempoh melebihi 11 bulan | Tiada bayaran balik |

(G) Pertukaran butir-butir hubungan

Anda hendaklah memaklumkan Syarikat tentang sebarang pertukaran butir-butir hubungan anda untuk memastikan semua surat sampai kepada anda tepat pada masanya.

(H)Manfaat Utama dan Kadar Premium Indikatif *

| PELAN | PELAN 1 | PELAN 2 | PELAN 3 | PELAN 4 | PELAN 5 | PELAN 6 |
|---|--|---------|---------|---------|---------|---------|
| MANFAAT | RM | RM | RM | RM | RM | RM |
| HAD TAHUNAN | | | | | | |
| • Had Tahunan Keseluruhan | 10,000 | 20,000 | 30,000 | 50,000 | 100,000 | 150,000 |
| MAKSIMUM SETIAP KETIDAKUPAYAAN | | | | | | |
| MANFAAT HOSPITAL | | | | | | |
| • Bilik Hospital dan Makanan (Maks. 150 hari) | 60 | 80 | 120 | 200 | 350 | 450 |
| • Unit Rawatan Rapi (Maks. 75 hari) | 120 | 160 | 250 | 400 | 500 | 600 |
| • Bekalan & Khidmat Hospital | • Bayaran yang dikenakan (tertakluk kepada Bayaran | | | | | |
| • Bilik Bedah | Munasabah dan Biasa Diamalkan) • | | | | | |
| MANFAAT PEMBEDAHAN | | | | | | |
| Perbelanjaan pembedahan termasuk perkara di bawah, kecuali pemindahan organ | | | | | | |
| • Ujian Diagnostik Pra-Pembedahan (Dalam masa 60 hari sebelum pembedahan) | 7,000 | 12,000 | 20,000 | 30,000 | 65,000 | 100,000 |
| • Rundingan Pakar Pra-Pembedahan (Dalam masa 60 hari sebelum pembedahan) | | | | | | |
| • Bayaran Pembedahan | | | | | | |
| • Bayaran Pakar Bius | | | | | | |
| MANFAAT PERUBATAN | | | | | | |
| Perbelanjaan perubatan untuk rawatan bukan-pembedahan, termasuk | | | | | | |
| • Ujian Diagnostik Pra-Hospital (Dalam masa 60 hari sebelum memasuki) | 7,000 | 12,000 | 20,000 | 30,000 | 65,000 | 100,000 |
| • Rundingan Pakar Pra-Hospital (Dalam masa 60 hari sebelum memasuki) | | | | | | |
| • Lawatan Pakar Perubatan Dalam Hospital (Maks. 60 hari) | | | | | | |
| • Rawatan Selepas Keluar Dari Hospital (Dalam masa 31 hari dari tarikh keluar) | | | | | | |
| MANFAAT PESAKIT LUAR | | | | | | |
| • Rawatan Pesakit Luar Bagi Kemalangan dan Kecemasan (Dalam masa 24 jam dan rawatan susulan sehingga maks. 31 hari) | • Bayaran yang dikenakan (tertakluk kepada Bayaran | | | | | |
| • Rawatan Fisioterapi Pesakit Luar (Dalam masa 90 hari dari tarikh keluar hospital / pembedahan) | Munasabah dan Biasa Diamalkan) • | | | | | |
| • Bayaran Ambulans | 200 | 250 | 300 | 500 | 700 | 1,000 |
| • Rawatan Kanser & Dialisis Buah Pinggang Pesakit Luar Bulanan | 1,000 | 2,000 | 3,500 | 4,000 | 5,000 | 6,000 |
| PEMINDAHAN ORGAN | | | | | | |
| • Pemindahan Jantung, Buah Pinggang, Paru-paru, Hati atau Tulang Sum-Sum | 5,000 | 12,500 | 20,000 | 30,000 | 50,000 | 60,000 |
| MANFAAT-MANFAAT LAIN | | | | | | |
| • Elaun Tunai Harian di Hospital Kerajaan (Maks. 150 hari) | 25 | 35 | 45 | 50 | 55 | 60 |
| • Manfaat Penjaga Harian Bagi Kanak-Kanak Yang Diinsuranskan (Maks. 60 hari) | 25 | 50 | 75 | 100 | 175 | 200 |
| PREMIUM TAHUNAN (usia pada tarikh lahir berikutnya) | | | | | | |
| LINGKUNGAN UMUR* | | | | | | |
| 30 hari - 17 tahun | 243 | 319 | 405 | 491 | 621 | 758 |
| 18 - 35 tahun | 248 | 336 | 411 | 493 | 641 | 754 |
| 36 - 45 tahun | 305 | 415 | 499 | 596 | 767 | 892 |
| 46 - 55 tahun | 433 | 595 | 713 | 854 | 1,098 | 1,285 |
| 56 - 60 tahun | 600 | 844 | 1,025 | 1,243 | 1,644 | 1,959 |
| 61 - 65 tahun (pembaharuan sahaja) | 746 | 1,101 | 1,358 | 1,690 | 2,361 | 2,854 |
| 66 - 70 tahun (pembaharuan sahaja) | 849 | 1,285 | 1,630 | 2,056 | 2,989 | 3,675 |

Syarat-syarat dan peraturan sebenar terkandung dalam Polisi asal yang akan dihantar kepada anda sebaik sahaja Syarikat bersetuju untuk menaja jamin dan meluluskan cadangan anda.

Maklumat penting di atas telah dijelaskan dengan secukupnya kepada saya.

.....
Nama Pemohon No. KP Tandatangan Tarikh

PENGISYTIHARAN OLEH EJEN

Saya mengisytiharkan dan mengesahkan bahawa:

- (A) Semua keterangan yang terkandung di dalam permohonan ini merupakan maklumat yang diberikan kepada saya oleh pemohon dan/atau hayati yang akan diinsuranskan, dan saya tidak menyimpan sebarang maklumat yang mungkin boleh mempengaruhi penerimaan bagi permohonan ini.
- (B) Saya tidak memberi pemohon dan/atau hayati yang akan diinsuranskan sebarang kenyataan yang bertentangan dengan peruntukan polisi asas syarikat.
- (C) Saya telah melihat salinan asal Kad Pengenalan dan mengesahkan identiti pemohon melalui penggunaan Kad Pengenalan atau dokumen lain-lain.

Tandatangan Ejen

Nama Ejen (Huruf Besar)

Tempat

Tarikh

Tarikh diterima di Pejabat Cawangan

Tarikh diterima di Ibu Pejabat

Pemberitahuan Khas:

Pemohon dengan ini telah diberitahu bahawa Syarikat telah melantik ejen/wakil yang telah diberikan kebenaran untuk mengurus atau merundingkan kontrak insurans bagi pihak Syarikat. Semua ejen/wakil yang diberikan kebenaran diberikan kad kebenaran.

PENGESAHAN PIHAK KETIGA

Selaras dengan pematuhan Seksyen 16(2) Akta Pencegahan Pengubahan Wang Haram 2001, saya dengan ini mengesahkan bahawa Nombor Kad Pengenalan Baru / Sijil Pendaftaran Perniagaan asal pemohon telah disahkan ketulenannya ketika urusniaga dijalankan.

Tandatangan

Nama

No. Kad Pengenalan

Tarikh

Pihak Ketiga "bermaksud ejen insurans, broker insurans atau kakitangan syarikat insurans.

Nota: Salinan Kad Pengenalan Baru / Sijil Pendaftaran Perniagaan pencadang hendaklah disertakan bersama-sama dengan borang cadangan ini untuk Polisi Persendirian jika bayaran premium melebihi RM50,000.00