AmGeneral Insurance Berhad (44191-P)
A member of the AmBank Group
Head Office: Menara Shell, No. 211, Jalan Tun Sambanthan, 50470, Kuala Lumpur, Malaysia
Postal Address: PO Box 11228, GPO Kuala Lumpur, 50740 W.P. Kuala Lumpur, Malaysia
(Service Tax Registration No.: B16-1808-31015443)

AmAssurance

Customer Contact Centre

Tel Call **1 300 80 3030** at local rates | **General line** +603 2268 3333 | **Email** customer@amassurance.com.my

GroupCare Personal Accident Proposal Form

Agent Name / Code :	Cover Note No :

STATEMENT PURSUANT TO FINANCIAL SERVICE ACT, Section 129, Schedule 9, Para 5: It is the duty of the Customer to take reasonable care not to make a misrepresentation to the licensed insurer when answering any question which the insurer may request that are relevant to the decision of the insurer whether to accept the risk or not and the rates and terms to be applied.

Name of Proposer :		Business Registration No. :	
Correspondence Address :			
Occupation / Profession :			
Website :	Phone No :	Fax No :	
Period of Insurance :	From :	To :	(both dates inclusive)

ALL QUESTIONS MUST BE ANSWERED BY THE PROPOSER AND MARK "3" WHERE APPLICABLE.

1. Is your Company at present covered with a Group Personal Accident Policy?	☐ Yes	☐ No	If Yes, please give details & particulars
2. Have you previously been insured?	☐ Yes	☐ No	If Yes, please give details & particulars of previous insurer.
3. Has any insurer in respect of life or accidental or sickness insurance over:-			
i) Decline to insure you?	☐ Yes	☐ No	If Yes, please give details & particulars
ii) Require special terms to insure you?	☐ Yes	☐ No	If Yes, please give details & particulars
iii) refuse to renew your insurance?	☐ Yes	☐ No	If Yes, please give details & particulars
iv) increased your premium on renewal?	☐ Yes	☐ No	If Yes, please give details & particulars
4. Have you/your employees ever made any claim in respect of death, accidental bodily injury, sickness against any insurer?	☐ Yes	☐ No	If Yes, please give details & particulars
5. During the last 5 years have you/your employees suffered from serous illness or received surgical treatment or hospitalizes?	☐ Yes	☐ No	If Yes, please give details & particulars
6. Are you/your employees suffered from any of the following :			
i) hearing or sights impaired?	☐ Yes	☐ No	If Yes, please give details & particulars
ii) any physical defects or infirmity?	☐ Yes	☐ No	If Yes, please give details & particulars
7. Are you/your employees will be involved in:-			
i) Professional sports	☐ Yes	☐ No	If Yes, please give details & particulars
ii) Offshore activities	☐ Yes	☐ No	If Yes, please give details & particulars
iii) Wood working activities	☐ Yes	☐ No	If Yes, please give details & particulars

8. Do you/your employees required the following extension: a) Strike, Riot & Civil Commotion risks? b) Motorcycling? c) Hunting? d) Amateur Sports : e) Water skiing? f) Football? g) Polo? h) Others. Please specify *Note - Any sports activities involving Professional participant is excluded under this policy.	☐ Yes ☐ No If Yes, please give details & particulars ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No _____
9. Any of your employees involved in occupation classified in class 3 & 4? Note : Please refer Classification of Occupation below	☐ Yes ☐ No If Yes, please give details & particulars

CLASIFICATION OF DECLARATION

Class 1 -- Individual engaged in professional, administrative, managerial, clerical and non-manual occupations

Class 2 -- Individual engaged in work of supervisory nature whose duties do not involve the use of tools or machinery or expose them to any special hazards

Class 3 -- Individual engaged in manual work not particularly hazardous in nature but involving the use of tools or light machinery (not wood-working machinery)

Class 4 -- Wood working activities and other than the above classification

Please provide details of Insured Person, Benefits, Amount Insured / Medical Expenses to be insured.

No.	Employee Name	Position	Sex M/F	Age	**Benefit 1** Death	**Benefit 2** Permanent Disablement	**Benefit 3** Temporary Total Disablement	**Benefit 4** Temporary Partial Disablement	**Benefit 5** Medical Expenses
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									
11.									
12.									
13.									
14.									
15.									

DECLARATION

I/We hereby confirm that I/we have undertaken reasonable care to answer all questions herein honestly and to the best of my/our knowledge, belief and reallocation and that I/we shall remain under a continuous duty to inform the Company of any change, amendment or addition to the aforesaid questions until the Policy is issued and comes into effect. I/We understand that the Company may avoid the policy and reject any claim payable thereunder (whether in whole or in part) in the event of deliberate misrepresentation, misdescription, error, omission or non-disclosure of fact (whether or not there was an inquiry/question raised pertaining to the same) with or without an intention to defraud the Company by me/us which would have been affected the premium payable or the acceptance of the risk by the Company.

☐ Yes ☐ No

I/We agree that the Company shall have the right to use my/our data and personal information for the purpose of the insurance operational process which might include transfer of data and personal information to the Company's related companies, subsidiaries and/or its holding company, outsourcing partners, re-insurers and solicitor but not limited to affiliate companies including their outsourcing partners.

☐ Yes ☐ No

I/We further agree that the Company, it's related partners and its related companies, subsidiaries and/or its holding company can share and use my/our data and personal information for the purpose of promoting the Company's and its related companies', subsidiaries' and/or its holding company's products, new services and support requirement; and marketing campaigns and activities and commercial transactions.

☐ Yes ☐ No

Signature / Company's Stamp : _____

Name : _____

Designation : _____

Date : _____

Anti-Money Laundering & Anti-Terrorism Financing Act

In compliance with Section 16(2) of the Anti-Money Laundering & Anti-Terrorism Financing Act 2011, I hereby certify that the Proposer's original NRIC/Business Registration Certificate/Passport was verified and authenticated by me at the Point of Sales.

Signature of Agents / Broker / Staff : _____

Name of Agents / Broker / Staff : _____

NRIC No. : _____

Date : _____

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