



Customer Contact Centre

Tel Call **1 300 80 3030** at local rates

General line +603 2268 6333

Email customer@amassurance.com.my

GroupCare Personal Accident Proposal Form

Agent Name / Code :		Cover Note No :	
STATEMENT PURSUANT TO FINANCIAL SERVICES ACT, Section 129, Schedule 9, Para 5: It is the duty of the Customer to take reasonable care not to make misrepresentation to the licensed insurer when answering any questions 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 "/" WHERE APPLICABLE.

1. Is your Company at present covered with a Group Personal Accident Policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please give details & particulars
2. Have you previously been insured?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please give details & particulars
ii) require special terms to insure you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please give details & particulars
iii) refuse to renew your insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please give details & particulars
iv) increased your premium on renewal?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please give details & particulars
5. During the last 5 years have you/your employees suffered from serious illness or received surgical treatment or hospitalises?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please give details & particulars
6. Are you/your employees suffered from any of the following :		
i) hearing or sights impaired?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please give details & particulars
ii) any physical defects or infirmity?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please give details & particulars
7. Are you/your employees will be involved in:-		
i) Professional sports	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please give details & particulars
ii) Offshore activities	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please give details & particulars
iii) Wood working activities	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please give details & particulars

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

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 /MedicalExpenses to be insured.

No.	Employee Name	Position	Sex M/F	Age	Benefit 1 Death	Benefit 2 Permanent Dsablement	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, its 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 AND PROCEEDS OF UNLAWFUL ACTIVITIES ACT 2001

For Agent/Staff Use Only

In Compliance with Section 16(2) of the Anti-Money Laundering, Anti-Terrorism Financing and Proceeds of Unlawful Activities Act 2001, I hereby certify that the Proposer's original NRIC / Business Registration Certificate / Passport was verified and authenticated by me at the Point of Sale.

Name of Proposer :

Cover Note/Policy No. :

VERIFICATION

Signature

NRIC No.

Name of Agent/Staff

Date