



LONPAC INSURANCE BHD (307414-T)

DMS/06/CP/P/001/Jan.

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Care Plus

PROPOSAL FORM / BORANG CADANGAN

STATEMENT PURSUANT TO SECTION 149(4) OF THE INSURANCE ACT, 1996, MALAYSIA.

You are to disclose in this proposal form, fully and faithfully all the facts which you know or ought to know, otherwise the policy issued hereunder may be void.

KENYATAAN MENGIKUT SEKSYEN 149(4) AKTA INSURANS 1996, MALAYSIA.

Anda adalah dikehendaki memberitahu dengan sepenuhnya semua butir-butir yang anda tahu atau yang anda patut tahu dalam borang cadangan ini, jika tidak polisi yang dikeluarkan menurut cadangan ini boleh menjadi tidak sah.

DUTY OF DISCLOSURE PURSUANT TO SECTION 150(1) OF THE INSURANCE ACT, 1996, MALAYSIA

It is the duty of the proposer to disclose to Lonpac Insurance Bhd a matter that he/she knows to be relevant (or a reasonable person in the circumstances could be expected to know to be relevant) to the decision of Lonpac Insurance Bhd on whether to accept the risk or not, and the rates and terms to be applied.

TANGGUNGJAWAB PENGEMUKAAN MENGIKUT SEKSYEN 150(1) AKTA INSURANS, 1996, MALAYSIA

Adalah menjadi tanggungjawab seorang pencadang untuk mendedahkan kepada Lonpac Insurance Bhd sesuatu perkara yang dia tahu sebagai relevan (atau seorang yang munasabah dalam keadaan itu mungkin dijangka untuk tahu sebagai relevan) kepada keputusan Lonpac Insurance Bhd sama ada untuk menerima atau tidak risiko, dan kadar dan terma yang hendak dipakai.

Agency A/C No:
No. Akaun Agensi

Policy No:
No. Polisi

YES! I wish to apply for LONPAC'S Care Plus Plan as

TYPE OF APPLICATION
(Please Tick)
JENIS PERMOHONAN
(Sila Tandakan)

NEW BUSINESS
PERNIAGAAN BARU

RENEWAL BUSINESS
PERNIAGAAN YANG DIPERBAHARUI

CHOICE OF PLAN
(Please Tick)

PLAN 1

PLAN 2

PLAN 3

PLAN 4

PLAN 5

SECTION A - DETAILS OF PROPOSER / BUTIR-BUTIR PENCADANG (please complete) / (sila lengkapkan)

Name (As in NRIC)
Nama (Seperti dalam Kad Pengenalan)
NRIC No. - - New Old
No. Kad Pengenalan Baru Lama
Passport No.
No. Pasport

(NRIC/Business Regn. Doc. Verified By Signature & Name of Agent/Staff)

Date of Birth - - Height cm Weight kg
Tarikh Lahir Tinggi Berat
dd / mm / yy / hh / bb / tt

Correspondence Address
Alamat Surat Menyurat
 Postcode
Poskod

Race Sex Male/Lelaki Female/Perempuan Nationality
Bangsa Jantina Warganegara
Tel. No. Hse Off H/P E-mail
No. Tel. Rumah Pejabat Tel. Bimbit E-mel
Allergies Blood Type Occupation
Alergi Jenis Darah Pekerjaan
(state exact duties) / (nyatakan tugas sebenar)

SECTION B - DETAILS OF SPOUSE / BUTIR-BUTIR SUAMI/ISTERI (please complete if insured) / (sila lengkapkan)

CHOICE OF PLAN (Please Tick) - should not be higher than the proposer's plan
PLAN 1 PLAN 2 PLAN 3 PLAN 4 PLAN 5

Name (As in NRIC)
Nama (Seperti dalam Kad Pengenalan)
NRIC No. - - New Old
No. Kad Pengenalan Baru Lama
Passport No.
No. Pasport

(NRIC/Business Regn. Doc. Verified By Signature & Name of Agent/Staff)

Proposer Pencadang		Spouse Suami/Isteri		Child 1 Anak Pertama		Child 2 Anak Ke-2		Child 3 Anak Ke-3	
Yes/ Ya	No/ Tidak	Yes/ Ya	No/ Tidak	Yes/ Ya	No/ Tidak	Yes/ Ya	No/ Tidak	Yes/ Ya	No/ Tidak
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(l) AIDS or AIDS-related conditions?
AIDS atau komplikasi yang berkaitan dengan AIDS?

(m) Any illness, disease or injury not mentioned above?
Sebarang penyakit atau kecederaan yang tidak dinyatakan di atas?

4. Have you or any of the person(s) to be insured's application for medical or hospitalisation type of policy been declined, restricted or accepted at other than normal terms?
If "yes", please state reasons and provide the name of the insurance company.
Pernahkah permohonan anda atau mana-mana orang yang akan diinsuranskan untuk polisi perubatan atau pemasukan ke hospital ditolak, dihadkan atau diterima di bawah syarat-syarat luarbiasa?
Jika "ya", sila nyatakan sebab dan berikan nama syarikat insurans.

Reason :
Sebab _____

Name of Insurance Company :
Nama Syarikat Insurans _____

Name :
Nama _____

Address :
Alamat _____

Tel. No. :
No. Tel _____

5. My/our usual doctor/physician is
(if none, details of doctor / physician last visited)
Doktor / pakar perubatan biasa saya/kami ialah
(jika tiada, beri butiran doktor / pakar perubatan yang dikunjungi akhir-akhir ini)

6. If any of the answer to question 2 & 3 above is "YES", please give details below. If this space is insufficient, please write on a separate sheet of paper.
Jika mana-mana jawapan dari soalan 2 & 3 adalah "YA", sila berikan butiran di bawah. Jika ruang tidak mencukupi, sila tulis dalam kertas berasingan.

Question No No. Soalan	
Name of Person Nama Orang Berkenaan	
Type and Date of Disability Jenis dan Tarikh Kecacatan	
Current Status of Disability Keadaan Kecacatan Kini	
Name and Address of Hospital and Physician Nama dan Alamat Hospital dan Pakar Perubatan	

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DECLARATION / AKUAN

I/We hereby declare that the above answers and statements are true, and that I/We have withheld no information whatsoever regarding this proposal. I/We agree that this Declaration and answers given above, as well as any application or declaration or statement made in writing by me/ourselves or anyone acting on my/our behalf shall form the basis of the contract between me/ourselves and **LONPAC INSURANCE BHD**. I/We hereby further declare and agree that in the event the declaration shall contain misstatement, misrepresentation, suppression and/or fraud, the issuance of the policy shall not be nor deemed to be a waiver of such misstatement, misrepresentation, suppression and/or fraud.

Saya/Kami mengaku bahawa jawapan dan kenyataan di atas adalah benar, dan Saya/Kami tidak menyembunyi sebarang maklumat mengenai cadangan ini. Saya/Kami bersetuju bahawa Akuan dan jawapan-jawapan yang diberikan di atas, dan sebarang permohonan atau Akuan atau kenyataan bertulis yang dibuat oleh saya/kami atau sesiapa yang bertindak bagi pihak saya/kami akan menjadi asas kepada kontrak antara saya/kami dan **LONPAC INSURANCE BHD**. Saya/Kami juga mengaku dan bersetuju bahawa sekiranya Akuan tersebut mengandungi kenyataan yang salah, penafsiran yang salah, penindasan dan/atau penipuan, maka pengeluaran polisi ini tidak harus dianggap sebagai menyingkirkan kenyataan yang salah, penafsiran yang salah, penindasan dan/atau penipuan tersebut.

I/We hereby authorise any hospital, surgeon, medical practitioner or clinic or other person who attended to me/us for any reason to disclose to **LONPAC INSURANCE BHD** any and all information with respect to any illness or injury and to provide copies of all hospital or medical records/certifications, including any earlier medical history. A photocopy of this authorisation shall be considered as effective and valid as the original.

Saya/Kami memberi kuasa kepada mana-mana hospital, doktor bedah, pengamal perubatan atau klinik atau pihak yang merawat saya/kami atas sebarang sebab memberikan apa-apa dan kesemua maklumat berkenaan dengan apa-apa penyakit atau kecederaan kepada **LONPAC INSURANCE BHD** dan memberikan salinan-salinan rekod/sijil hospital atau perubatan termasuk sebarang sejarah perubatan sebelumnya. Salinan pemberian surat kuasa ini harus dianggap sebagai efektif dan sah seperti yang asal.

I/We understand that **LONPAC INSURANCE BHD** reserves the right to accept, decline or impose special conditions in the event the information declared is not according to standard guidelines as imposed by its underwriters.

Saya/Kami memahami bahawa **LONPAC INSURANCE BHD** berhak menerima, menolak dan mengenakan syarat-syarat khas sekiranya maklumat yang diumumkan tidak mengikut garis panduan standard yang dikenakan oleh pengunderait.

I/We also understand that coverage will only be effective after **LONPAC INSURANCE BHD** has accepted and approved the Proposal Form and subject to payment of premium to **LONPAC INSURANCE BHD**. Saya/Kami juga memahami bahawa perlindungan akan hanya berkuatkuasa selepas **LONPAC INSURANCE BHD** menerima dan meluluskan Borang Cadangan ini dan tertakluk kepada syarat bahawa premium telah dibayar kepada **LONPAC INSURANCE BHD**.

Signature of Proposer / Tandatangan Pencadang

Date / Tarikh

Signature of Spouse (if insured)
Tandatangan Suami/Isteri (jika diinsuranskan)

Date / Tarikh

ESSENTIAL INFORMATION ON THE PURCHASE OF Care Plus

Terms of issue:

- The Policy is yearly renewable. Lonpac may invite renewal on existing terms, with premium revision, with certain restriction of coverage or it may be declined if there is any material change in occupation, duties or pursuits or any injury, disease, physical defect or infirmity of which the Insured Person has become aware or been affected.
- If the Insured Person is hospitalized at a 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.
- If the proposal or declaration of the Insured Person is untrue in any respect or if any material fact affecting the risk be incorrectly stated herein or omitted therefrom, the Policy shall be void.

Major benefits and indicative premium rates:

- The Schedule of Benefits and Annual Premium Table as contained in the brochure.

Major benefit limitations:

- Pre-existing illness.
- Specified Illnesses occurring during the first 120 days of continuous cover.
- Any medical or physical conditions arising within the first 30 days of the Insured Person's cover or date reinstatement whichever is latest except for accidental injuries.

Proposer sign off :

The above essential information on major features of the product has been satisfactorily explained to me.

Name of Proposer

New NRIC No.

Signature of Proposer

Date of Signature

PREMIUM

Please fill in the space provided.

Insured Person	Age Next Birthday	Plan	Premium (RM)
Proposer			
Spouse			
Child 1			
2			
3			
4			
5			
Stamp Duty (RM10 per policy)			10.00
Total			

Collection of payment shall not be construed as acceptance of your proposal until the proposal is approved by the insurer and is also subject to the clearance of your payment if it is made by cheque or credit card. In the event that the credit card is declined, the proposal as well as the receipt are deemed automatically cancelled and the Insurer shall not be liable for any claims whatsoever.

PAYMENT AUTHORISATION

Payment by Cash (RM) _____

Payment by Cheque made payable to LONPAC INSURANCE BHD.
Cheque No. _____ (RM) _____

I hereby authorise LONPAC INSURANCE BHD to charge my premium amount: (RM) _____ to my VISA/MasterCard account.

Credit Card No. _____ Card expiry date _____

Issuing Bank

Cardholder's Signature

Date