

Application Form

Statement Pursuant to Section 149(4) of the Insurance Act, 1996. You are to disclose in this application form, fully and faithfully all the facts which you know or ought to know, otherwise the policy issued hereunder may be void.

YES, I wish to apply for **Emergency Medical Assist Plan**
Commencement date of Insurance:

My Choice of Plan (please tick ✓)

PLAN 1 PLAN 2

Personal Details of Applicant

Name: _____
(as per Identity Card)

IC No: (old) _____ (new) _____

Address: _____

Postcode: _____ State: _____

Tel: (Home) _____ (Office) _____

Present Employer: _____ Handphone: _____

Details of person to be insured

Name: _____
(as per Identity Card)

IC No: (old) _____ (new) _____

Address: _____

Postcode: _____ State: _____

Tel: (Home) _____ (Office) _____

Date of Birth: _____ Sex: _____

Height (cm): _____ Weight(kg): _____

Relationship to applicant: self spouse child

Occupation: _____

Please answer the following questions:

- Does the person to be insured have any deformity or illness?
 YES NO
- Has the person to be insured ever undergone any surgical operation?
 YES NO
- Has the person to be insured ever been hospitalised for any illness or injury?
 YES NO
- Is the person to be insured currently under medication or supervision of a doctor or physician for any illness or disability?
 YES NO
- Has the person to be insured ever been advised to have a surgical operation which has yet to be performed?
 YES NO
- If any of the preceding five questions are answered "YES", please complete details below:-

Question Number	Date of Disability	Description of Disability & Result of Treatment	Name & Address of Physician & Hospital
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

7. My usual doctor is

Name: _____

Address: _____

Tel: _____

8. Persons to contact in case of emergency

Name: _____

Address: _____

Tel: _____

Use separate Application Form for each applicant.

Declaration

I hereby declare that the foregoing statement and particulars are true and complete and I have not withheld any information that may influence the acceptance of this application. I agree that this application and declaration shall be the basis of the contract between me and The Pacific Insurance Berhad and agree to accept the Company's Policy and be subject to the terms and conditions therein.

It is further understood and agreed that the cover will only be effective if it has been accepted by the Company and the applicable premium has been paid.

I hereby authorise any hospital, surgeon, medical practitioner, clinic or other person who has attended to the person to be insured for any reason, to disclose to The Pacific Insurance Berhad any and all information with respect to any illness or injury and to provide copies of all hospital or medical records, certification, including earlier medical history. A photostat copy of this authorisation shall be considered as effective and valid as the original.

Date

Signature of Proposer

Date

Signature of Witness

Name of Witness

Premium

PLAN	RM
STAMP DUTY	RM 10.00
TOTAL	RM

Payment

Payment by cash (RM) _____

Payment by cheque (No.) _____

Date _____ (RM) _____

I hereby authorise "The Pacific Insurance Berhad" to charge my premium amount RM _____ to my VISA/MASTER card account.

□□□□ - □□□□ - □□□□ - □□□□

Card expiry date: _____ Issuing Bank: _____

Date _____ Signature of Cardholder _____

Name of Agent/Branch

Agency No.

For Office Use:

Name of Agent _____ Agency No: _____

PIB Branch _____

Date of payment received _____

Remarks _____

Please affix agent's rubber stamp