

GROUP PROPOSAL FORM FOR HOSPITAL & SURGICAL INSURANCE

STATEMENT PURSUANT TO SECTION 149(4) OF THE INSURANCE ACT 1996. You are to disclose fully and faithfully all the facts which you know, or ought to know, regarding your employees to be insured with, otherwise the Policy issued hereunder may be void.

NAME OF EMPLOYER :- _____

ADDRESS OF EMPLOYER :- _____

BUSINESS OF EMPLOYER :- _____

PERSON TO CONTACT :- _____ **TEL NO.** _____

BROKER/AGENT :- _____ **ACCOUNT NO.** _____

PERIOD OF INSURANCE : From dd mm yy To dd mm yy

POLICY RENEWAL DATE : On dd mm yy

CLASSIFICATION OF BENEFITS

Please classify employees' occupation/designation

Employee Position	Plan	Employee Position	Plan
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ELIGIBILITY

- (a) Employees becoming eligible on the effective date will be employees who are actually on full-time work.
 (b) Future employees will become eligible :-
 On the date of employment.
 Upon completion of continuous service of _____ months/years, provided they are actively at work

SCHEME OF INSURANCE

Premium of insurance will be borne by :

- Employer : 100% participation of eligible employees and/or dependants are required. Dependants coverage will not become effective before the insurance of employees become effective.
 Employee : Minimum 75% participation of eligible employees are required. Dependant coverage will not become effective before at least 75% of the eligible employees having dependants subscribe to the plan both for themselves and their dependants.

Dated at _____ this _____ of _____
 (Location) (Day) (Month) (Year)

Witnessed by : _____ For & On Behalf of Employer :

 (Signature)

 (Signature)

 (Name & Title)

 (Name & Title)

Stamp of Employer :

Please submit this Proposal Form in duplicate. Photocopy of this Form is accepted.

VERIFICATION ON AUTHENTICITY OF IDENTITY

(For Use by Insurance Staff or Intermediary only)

In compliance with section 16(2) of Anti-Money Laundering Act 2001, I hereby confirm the following :

- Original Identity document sighted for Individuals/Group with single or annual premium exceeding RM5,000
 Photocopy of identity document attached for Individuals with single or annual premium exceeding RM50,000
 Photocopy of identity document attached for Group with single or annual premium exceeding RM100,000

 Date

 Signature

 Name of Staff or Intermediary

 NRIC No.