Allianz

Bahasa Malaysia version – **Click Here**

**Allianz General Insurance Company (Malaysia) Berhad** (200601015674)
(Licensed under the Financial Services Act 2013 and regulated by Bank Negara Malaysia)

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# Allianz MediCure Proposal Form

Period of Insurance:

From D D – M M – Y Y Y Y To D D – M M – Y Y Y Y

Agent Code:

Please complete in CAPITAL LETTERS/Tick ☑ in the appropriate boxes.

## Part 1 - Particulars Of Proposer

| | | | |
|---|---|---|---|
| Salutation | ☐ Mr. ☐ Madam ☐ Miss ☐ Others (please specify) | | |
| Name | | | |
| Address | | | |
| Postcode | | City | |
| State | | Country | |
| Mobile No. | – | | |
| E-mail | | | |
| ID Type | ☐ NRIC ☐ Passport ☐ Police/Army | | |
| ID No. | | | |
| Date of Birth | D D – M M – Y Y Y Y | Gender | ☐ Male ☐ Female |
| Height | cm Weight kg | | |
| Nationality | ☐ Malaysian ☐ Others (please specify) | | |
| Occupation | | | |

## Proposer is Corporate Body

| | |
|---|---|
| ID Type | ☐ Business Registration No. ☐ New Business Registration No. |
| ID No. | |
| Tax ID No. (TIN) | |
| SST No. | |
| *Nature of Business | |

Note: *If Proposer is Corporate Body, Nature of Business is required.

## Part 2 – Needs Based Assessment

| No. | Questions |
|---|---|
| 1. | What are your needs/priorities for purchasing health insurance? (You can choose multiple priorities)<br>☐ I am investing in an insurance now to cover for healthcare during my old age<br>☐ I don't have enough savings to pay for any emergency medical bills<br>☐ Others (please specify)<br>Remarks: |
| 2. | Are you currently employed and/or self-employed (e.g. business owner)?<br>☐ Yes ☐ No |

| | |
|---|---|
| 3a. | If employed/self-employed, what is your average monthly income?<br>(Estimated gross monthly income before taxes and EPF contributions)<br>Average Monthly Income (RM) : _____ ☐ Prefer not to disclose |
| 3b. | If unemployed, how will you pay for this medical insurance?<br>☐ Current Savings<br>☐ Passive Income (Rental, Investments, Stocks, Real Estate, etc.)<br>☐ Other Sources (please specify)<br>Remarks: |
| 4. | Do you have any existing medical and/or hospitalization and surgical insurance (including employee benefits provided by your employer)?<br>☐ Yes ☐ No<br>If Yes, what is the total combined annual limit of your existing medical and/or hospitalization and surgical insurance policy(ies)?<br>Total Combined Annual Limit (RM) : _____ ☐ Prefer not to disclose |
| 5. | What is your estimated monthly disposable income? (Income minus expenditure and any ongoing financial obligations)<br>Monthly Disposable Income (RM): _____ ☐ Prefer not to disclose |
| 6. | Would you consider paying for your medical bills upfront first and then obtain reimbursement from Allianz General Insurance Company (Malaysia) Berhad later to enjoy cheaper premiums on your medical policy?<br>☐ Yes ☐ No |

Note: If Insured Person is a minor (i.e. under 18 years old), the parent/legal guardian is to answer this Needs Based Assessment.

**Important Notice**

1. Your intermediary must have sufficient information before making a suitable recommendation. The information that you provide will be the basis on which advice will be given.
2. If you choose not to provide all relevant information requested, your intermediary may not be able to provide you suitable advice and as a result, you may risk making a financial commitment to a medical insurance policy inappropriate to your needs.
3. Your intermediary is required to preserve the confidentiality of information disclosed by you and restrict the use of such information only for the purpose of recommending medical insurance.
4. You must ensure that important information regarding the policy/plan is disclosed to you and that you understand the information disclosed. Where there is ambiguity, you should seek an explanation from the intermediary or Allianz General Insurance Company (Malaysia) Berhad.
5. Prior to making a decision to purchase/participate in any medical policy, you must satisfy yourself that the policy/plan best meets your insurance needs based on your financial resources.

## Part 3 - Health Declaration (Individual Only)

| No. | Questions | Yes | No |
|---|---|---|---|
| 1. | Have your applications for any medical coverage been declined, restricted, or otherwise accepted with modified terms? | ☐ | ☐ |
| 2. | Have you suffered from, diagnosed, received treatment or been under medication, hospitalized (or advised to seek treatment, but did not proceed or refuse treatment) for any medical condition, illness or disease within the last 5 years? If yes, please provide details below for each item:<br>(a) Name of the medical condition, illness or disease.<br>(b) Date of diagnosis, details of recurring episodes (if any), and the current status of the medical condition, illness or disease.<br>(c) Describe any treatments or medications you have received within the last 5 years.<br>(d) If you have been hospitalized or advised to seek treatment but did not proceed or refuse treatment, please explain the reasons behind your decision and the consequences that resulted from it, if any. | ☐ | ☐ |
| 3. | Do you suffer from any physical impairment or limitations in performing daily activities* (unable to perform 2 or 3 activities without assistance), physical weakness or ailments, any abnormality, or congenital conditions? If yes, please provide details below for each item:<br>(a) Type of disability or medical condition.<br>(b) Date of diagnosis of the disability / medical condition.<br>(c) Treatments or medications you have received for the disability / medical condition.<br>Note: * Daily activities mean mobility, dressing, personal hygiene, toileting, eating and/or transfer. | ☐ | ☐ |

Note: If Proposer is a Corporate Body, the questions is only applicable if number of insured person between 1 to 20 persons.

If any of the answers is 'Yes' to the above questions, please give details below and number your answers to correspond with the number of the questions.

| No. | Details |
|---|---|
| | |
| | |
| | |
| | |

## Part 4 - Plan Selection And Premium Details, Please Tick ☑ Plan Selected

| Plan Required | Non Cashless | Cashless* | Deductible (Optional) | Total Premium (RM) |
|---|---|---|---|---|
| ☐ Plan 1 OAL RM50,000<br>☐ Plan 2 OAL RM80,000<br>☐ Plan 3 OAL RM120,000<br>☐ Plan 4 OAL RM150,000<br>☐ Plan 5 OAL RM250,000 | ☐ | ☐ | ☐ Option 1 RM10,000<br>☐ Option 2 RM20,000<br>☐ Option 3 RM30,000<br>☐ Option 4 RM40,000<br>☐ Option 5 RM50,000 | 0.00 |
| | | | MCO Fee (RM) | 0.00 |
| | | | Service Tax (RM) | 0.00 |
| | | | Stamp Duty (RM) | 10.00 |
| | | | **Total Amount (RM)** | 10.00 |

Notes:

1. *MCO fee is RM18 for Cashless option only.
2. For Corporate Body, premium is subject to 8% of Service Tax.
3. Premium is further subject to RM10 Stamp Duty.

## Part 5 - Declaration

I hereby declare that I have fully and accurately answered the questions in this proposal form. I hereby authorize any hospital, surgeon, medical practitioner or clinic or other person who attends to me for any reason to disclose to the Company any and all information with respect to any illnesses or injury and to provide copies of all hospital or medical records/certifications, including any earlier medical history. A photocopy of this authorization shall be considered as effective and valid as the original. I acknowledge that the liability to the Company does not commence until the proposal is accepted by and the premium paid to the Company.

## For Individual Client

_____

Signature of Proposer

Name

ID Type ☐ NRIC ☐ Passport ☐ Police/Army

ID No.

Date D D – M M – Y Y Y Y

Note: 1. Where the Insured Person is a child aged below eighteen (18) years, this proposal must be signed by his/her parent/guardian. Please state Name, ID Type and ID No. of the Parent/Guardian.

## For Company Client

Witness By: | For and on Behalf of the Employer | Stamp of the Employer

Signature _____ _____ _____

Name

Designation

Date D D – M M – Y Y Y Y