IB002

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Tel: (603) 4043 2100 Fax: (603) 4043 8680

HEALTH CERTIFICATE

WARNING : Pursuant to Section 149 (4) of the Insurance Act, you are to disclose in this application form, fully and faithfully all the facts which you know or ought to know, otherwise the application approved hereunder may be void.`

Policy No ………………………….. Policyowner ………………………………. Life Assured …………………………

Application For : ____________________ Since the date of application of this policy:	Answer On Life Assured		Answer On Policy Owner	
	YES	NO	YES	NO
1. Have you had any illness or injury? Will you plan to have or have you been advised to undergo surgical or other treatment in the future? Please also state whether you have fully recovered.				
2. Have you ever been hospitalized? State also whether you have fully recovered.				
3. Have you had any X-rays, ECG, Blood tests or other medical test done? (If yes, give details, type of test done, date and results in the column below)				
4. **(For Females Only)** Are you now pregnant? (If yes, please state how many months pregnant)				
5. Has any of your application for insurance policy ever been declined, postponed, modified, rated or is now pending? (If yes, give the name of insurance company, policy reference No. and state cause/reason in the column below)				
6. Have you ever made any accident/disability/hospital benefits claim against: (a) AmAssurance Berhad (b) Other insurance company? (If answer to (b) is yes, please let us have a copy of the claims report)				
7. What is your present height and weight?				
8. What is your present occupation? Are you engaged in any hazardous hobbies/sports?				

Please give details if you have answered 'YES' to any of the question above. (Indicate the questions number you are answering

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I DECLARE, on behalf of myself and of any person(s) who may have or claim any interest in said policy, that the above answers are true and complete, and **I AGREE** that they shall be taken as the basis of the proposed policy, reinstatement, change or addition. I also agree that the reinstatement change or addition shall not be considered as effected by reason of any money paid or settlement made on payment of; or an account of any premium until such reinstatement, change or addition is approved by the company. I agree to accept return of such payment made should the company decline the reinstatement, change or addition.

I FUTHER AGREE that if the policy is reinstated, the Incontestability and Suicide provisions shall have effect from the reinstatement approval date. It is also **UNDERSTOOD** and **AGREE** that should the above statements regarding my health (and the health of the child assured, if applicable) be found to be contrary to the truth, the reinstated, altered or varied policy contract shall be absolutely void.

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Signature of Witness	**Signature of Life Assured**	**Signature of Policyowner**
Name :	**Date :**	**Date :**
I.C.No :		