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

SIMON POON AGENCY

Office: 48-A, Jalan Hujan Rahmat Dua, Taman O.U.G. Off Jalan Kelang Lama, 58200 Kuala Lumpur, Malaysia.
Tel: 603-7785 3699. Fax:603-7785 3699. H/P:016-234 8808

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* [X]

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. *No. Kad Pengenalan* New *Baru* – – Old *Lama*

Passport No. *No. Pasport*

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

Date of Birth *Tarikh Lahir* – – dd / mm / yy / *hh / bb / tt*

Height *Tinggi* cm *sm*

Weight *Berat* kg *kg*

Correspondence Address *Alamat Surat Menyurat*

Postcode *Poskod*

Race *Bangsa*

Sex *Jantina* Male/*Lelaki* Female/*Perempuan*

Nationality *Warganegara*

Tel. No. *No. Tel.* Hse *Rumah*

Off *Pejabat*

H/P *Tel. Bimbit*

E-mail *E-mel*

Allergies *Alergi*

Blood Type *Jenis Darah*

Occupation *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. *No. Kad Pengenalan* New *Baru* – – Old *Lama*

Passport No. *No. Pasport*

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

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Date of Birth / *Tarikh Lahir* ☐☐ – ☐☐ – ☐☐☐☐ (dd / mm / yy / *hh / bb / tt*)

Height / *Tinggi* ☐☐☐ cm / *sm*

Weight / *Berat* ☐☐☐ kg / *kg*

Race / *Bangsa* ☐

Sex / *Jantina* Male/*Lelaki* ☐ Female/*Perempuan* ☐

Nationality / *Warganegara* ☐

Allergies / *Alergi* ☐

Blood Type / *Jenis Darah* ☐

Occupation / *Pekerjaan* ☐ (state exact duties) / *(nyatakan tugas sebenar)*

SECTION C – DETAILS OF CHILDREN / *BUTIR-BUTIR ANAK*

(please complete if insured) / *(sila lengkapkan jika diinsuranskan)*

CHOICE OF PLAN
(Please Tick) – should not be higher than the proposer's plan

PLAN 1 ☐ PLAN 2 ☐ PLAN 3 ☐ PLAN 4 ☐ PLAN 5 ☐

	Child 1 / *Anak Pertama*	**Child 2 / *Anak ke-2***	**Child 3 / *Anak ke-3***
Name / *Nama*			
Sex (Male/Female) *Jantina (Lelaki/Perempuan)*			
Date of Birth *Tarikh Lahir*			
NRIC/Birth Cert. No. *No. Kad Pengenalan/Sijil Lahir*			
(NRIC/Birth Cert. Verified By _____ ***Signature & Name of Agent/Staff)***			
Allergies / *Alergi*			
Blood Type / *Jenis Darah*			

(If this space is insufficient, please write on a separate sheet of paper) / *(Jika ruang tidak mencukupi, sila tulis dalam kertas berasingan)*

HEALTH DECLARATION OF PERSON(S) INSURED / *AKUAN KESIHATAN ORANG YANG DIINSURANSKAN*

(Please Tick ✓) / *(Sila Tandakan ✓)*

	Proposer *Pencadang* Yes/*Ya*	Proposer No/*Tidak*	Spouse *Suami/Isteri* Yes/*Ya*	Spouse No/*Tidak*	Child 1 *Anak Pertama* Yes/*Ya*	Child 1 No/*Tidak*	Child 2 *Anak Ke-2* Yes/*Ya*	Child 2 No/*Tidak*	Child 3 *Anak Ke-3* Yes/*Ya*	Child 3 No/*Tidak*
1. Do you or any of the person(s) to be insured have Health Insurance with us or any other company? *Adakah anda atau mana-mana orang yang akan diinsuranskan mempunyai Insurans Kesihatan dengan kami atau mana-mana syarikat lain?*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. Have you or any of the person(s) to be insured: *Adakah anda atau mana-mana orang yang akan diinsuranskan:*										
(a) Suffered or have any physical defect, infirmity or congenital condition? *Mengalami atau mempunyai apa-apa kecacatan fizikal, keuzuran atau penyakit kongenital?*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(b) Currently under observation or receiving treatment or taking any medication? *Kini di bawah pemerhatian atau menerima rawatan atau apa-apa pengubatan?*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(c) Undergone any surgical operation or suffered any disease or injury? *Telah menjalani apa-apa pembedahan atau menghidapi apa-apa penyakit atau kecederaan?*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(d) Ever been advised to have a surgical operation which has not been performed? *Pernah dinasihati untuk menjalani operasi pembedahan yang belum dilakukan?*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. Have you or any of the person(s) to be insured ever been told that you or them suffered from or had been treated for any of the following: *Adakah anda atau mana-mana orang yang akan diinsuranskan pernah diberitahu bahawa anda atau mereka menghidapi atau pernah dirawati mana-mana daripada yang berikut:*										
(a) Chronic cough, spitting of blood, asthma, hay fever, pleurisy, tuberculosis or any other disease of the respiratory system? *Batuk kronik, ludah berdarah, asma, demam alergi, pleurisi, batuk kering atau apa-apa penyakit sistem pernafasan?*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(b) High or low blood pressure, heart disease, chest pain, heart attack, shortness of breath, palpitation or heart disorder? *Tekanan darah tinggi atau rendah, penyakit jantung, sakit dada, serangan penyakit jantung, sesak nafas, debaran jantung yang abnormal atau gangguan jantung?*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(c) Epilepsy, fits, dizziness, mental or nervous disorder? *Epilepsi, sawan, pening, gangguan mental atau sistem saraf?*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(d) Diabetes, sugar or blood in urine, kidney, colic or hernia? *Kencing manis, kandungan gula atau darah dalam air kencing, penyakit buah pinggang, kolik atau hernia?*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(e) Diseases of the eyes, ear, nose or throat? *Penyakit mata, telinga, hidung atau tekak?*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(f) Arthritis, sciatica, rheumatism, back, spine, bone, joint, muscle or skin disorder? *Sakit sendi, penyakit sengal pada pangkal paha, radang otot dan sendi, penyakit belakang, tulang belakang, tulang, sendi, otot atau penyakit kulit?*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(g) Ulcer or disorder of the stomach, intestines, haemorrhoids or rectal disorder? *Ulser atau penyakit perut, usus, buasir atau penyakit rektum?*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(h) Gall bladder stone or liver disease or any type of hepatitis? *Batu pundi hempedu atau penyakit hati atau mana-mana jenis hepatitis?*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(i) Cancer, tumour, or growth of any kind of any organ system? *Barah, tumor atau sebarang ketumbuhan pada mana-mana sistem organ?*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(j) Anaemia, thyroid disorder (such as goitre), or rheumatic fever? *Anemia, gangguan tiroid (seperti goiter) atau demam reumatik?*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
(k) Sexually transmitted diseases such as syphilis, gonorrhoea or non-specific urethritis? *Penyakit-penyakit berjangkit melalui hubungan seks seperti penyakit kelamin, gonorea atau uretritis yang tidak khusus?*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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	Proposer *Pencadang* Yes/*Ya*	Proposer No/*Tidak*	Spouse *Suami/Isteri* Yes/*Ya*	Spouse No/*Tidak*	Child 1 *Anak Pertama* Yes/*Ya*	Child 1 No/*Tidak*	Child 2 *Anak Ke-2* Yes/*Ya*	Child 2 No/*Tidak*	Child 3 *Anak Ke-3* Yes/*Ya*	Child 3 No/*Tidak*
(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 _____

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)

Name :
Nama _____

Address :
Alamat _____

Tel. No. :
No. Tel _____

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*	

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*	

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*	

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*

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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)			
		Total	**0.00**

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 _____

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Premium Table

Care Plus

Annual Premium Table (RM)					
Age Group	**Plan 1**	**Plan 2**	**Plan 3**	**Plan 4**	**Plan 5**
• 30 days to 18 years	443	397	319	279	239
• 19 to 35 years	599	535	426	372	316
• 36 to 45 years	817	728	577	501	423
• 46 to 55 years	1,190	1,058	835	723	608
• 56 to 60 years	1,532	1,361	1,072	926	777
• 61 to 65 years (for renewal only)	1,968	1,747	1,373	1,185	993
• 66 to 70 years (for renewal only)	2,653	2,353	1,847	1,592	1,331

You should satisfy yourself that this plan will best serve your needs and the premium payable is an amount you can afford.

Note:

1. Premium charged is according to age of next birthday.
2. Renewal premium will automatically be adjusted on entering the next age group.
3. Annual Premium is based on standard health status and occupational risk. Premium may be adjusted accordingly should there be adverse variations to your health or occupation.
4. Premium excludes stamp duty and service tax.
5. The plans shall cover eligible persons between the ages of 30 days to 60 years. Renewable up to 70 years.
6. Children between the ages of 30 days and 18 years must be enrolled together with at least one of their parents and the plan chosen must not be higher than the accompanying parent.
7. A Family Discount of 10% on the total premium payable will be allowed to a family with three (3) or more members insured under a single policy.
8. Family members refer strictly to legal spouse and/or children.

PRODUCT DISCLOSURE SHEET

(Please read this Product Disclosure Sheet before you decide to take out *Care Plus*. Be sure to also read the general terms and conditions.)

LONPAC INSURANCE BHD (307414-T)

Care Plus
(Hospitalisation and Surgical Insurance)

1 January 2010

1. What is this product about?

This policy provides for hospitalisation and surgical expenses incurred due to illnesses or accidents covered under the policy.

2. What are the covers / benefits provided?

This policy covers:

- **In-patient and Day-patient Treatment**
  - Hospital Room & Board
  - Intensive Care Unit
  - Hospital Supplies & Services
  - Surgical Fees
  - Anaesthetist Fee
  - Operating Theatre
  - In-Hospital Physician Visit
  - Organ Transplant
  - Day Surgery
- **Outpatient Treatment**
  - Pre-Hospital Specialist Consultation
  - Pre-Hospital Diagnostic Tests
  - Post-Hospitalisation Treatment
  - Emergency Accidental Outpatient Treatment
  - Emergency Accidental Outpatient Dental Treatment
  - Outpatient Physiotherapy Treatment
  - Outpatient Kidney Dialysis Treatment
  - Outpatient Cancer Treatment
- **Additional Benefits**
  - Insured Child's Daily Guardian Benefit
  - Home Nursing Care
  - Medical Report Fee
  - Ambulance Fees
  - Accidental Death Benefit
  - Daily Cash Allowance at Government Hospital
  - Government Service Tax

Amount covered is stated in the Schedule of Benefits of the policy contract.

A Medical Card is provided to facilitate admission at participating hospitals. For certain medical conditions, assistance is provided to obtain Second Opinion from leading medical centres.

Duration of cover is for one year. You need to renew your insurance cover annually.

3. How much premium do I have to pay?

The premium you have to pay may vary depending on your choice of plan, age group and our underwriting requirements:

Example
If you are age 30 on your next birthday, the estimated gross premium which is including agent's commission but excluding service tax and stamp duty is RM316.

Renewal premium will automatically be adjusted on entering the next age group. Premium may also be adjusted should there be adverse variations to your health or occupation.

4. What are the fees and charges that I have to pay?

• Service tax (for business entity)	• 5%
• Stamp duty	• RM10

5. What are some of the key terms and conditions that I should be aware of?

- Duty of disclosure - You must disclose all material facts which you know or ought to know such as medical condition, and state your age correctly. You must ensure that the proposal form is completed accurately as it forms the basis of the insurance contract.
- Residence overseas - No benefits shall be payable for medical treatment outside Malaysia if you are outside Malaysia for more than 90 consecutive days.
- Cooling-off period - You may cancel the policy within 15 days after you have received the policy. The premium that you have paid (less any medical expenses incurred in the issuance of the policy) will be refunded to you. Renewal has no cooling-off period.

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• Change in risk	- You shall give immediate written notice to us of any material change in your occupation, business, duties or pursuits and pay any additional premium that may be required.
• Upgraded room & board co-payment	- You have to bear 20% of the other eligible benefits described in the Schedule of Benefits if hospitalised at a published Room & Board rate which is higher than your eligible benefit.
• Yearly renewable policy up to age 70	- Renewal may be invited based 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 of pursuits or any injury, diseases, physical defect or infirmity of which you have become aware or been affected.
• Claims	- Upon the happening of a Disability, you shall notify us in writing within 30 days.

Note:
This list is non-exhaustive. Please refer to the policy contract for the full list of terms and conditions under this policy.

6. What are the major exclusions under this policy?

This policy does not cover:
- Pre-existing illness, and specified illnesses during the first 120 days
- Any medical or physical conditions arising within the first 30 days after the effective date of the insurance except for accidental injuries
- Congenital abnormalities
- Plastic/cosmetic surgery
- Dental treatment not arising from accidental injuries
- Pregnancy
- Hazardous sports

Note:
This list is non-exhaustive. Please refer to the policy contract for the full list of exclusions under this policy.

7. Can I cancel my policy?

You may cancel the policy at any time by giving written notice to us. Upon cancellation, any refund of the premium would be based on the conditions stipulated in the policy contract.

8. What do I need to do if there are changes to my contact details?

It is important that you inform us of any change in your contact details to ensure that all correspondences reach you in a timely manner.

9. Where can I get further information?

Should you require additional information about hospitalisation and surgical insurance, please refer to the *insuranceinfo* booklet on 'Medical & Health Insurance', available at all our branches or you can obtain a copy from the insurance agent or visit www.insuranceinfo.com.my.

If you have any enquiries, please contact us at:

Customer Service Department
Lonpac Insurance Bhd
LG Floor, Bangunan Public Bank
6 Jalan Sultan Sulaiman
50000 Kuala Lumpur
Tel : 03 2262 8688
Fax : 03 2715 1332
E-mail : customerservice@lonpac.com

Authorised agent:
SIMON POON AGENCY
48-A, Jalan Hujan rahmat Dua(2)
Taman O.U.G. 58200 Kuala Lumpur
Website: http://www.simonpoonagency.net
Tel/Fax: 03 - 7785 3699; 016 234 8808

E-mail : simon@simonpoonagency.net

10. Other types of Hospitalisation and Surgical Insurance cover available

None

IMPORTANT NOTE:
YOU SHOULD SATISFY YOURSELF THAT THIS POLICY WILL BEST SERVE YOUR NEEDS. YOU SHOULD READ AND UNDERSTAND THE INSURANCE POLICY AND DISCUSS WITH THE AGENT OR CONTACT US DIRECTLY FOR MORE INFORMATION.

This Product Disclosure Sheet is for general information only and is valid as at 01.01.2010.

Interactively prepared by SIMON POON AGENCY for attended client only