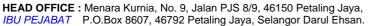
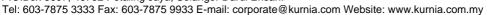


MI-UW-F004 REV: C

(A member of the Kurnia Group of Companies) Company Number : 44191-P







KURNIA GROUP MEDICAL INSURANCE PROPOSAL FORM		
Agent's / Broker's Name :	Branch :	
Agent's Code :	Marketing Exec. :	
1. EMPLOYER'S DETAILS		
Name of Company :	Year Established:	
Address :	Postcode :	
Nature of Business / Occupation :	Telephone No. :	
Contact Person :		
2. ELIGIBILITY DEFINITION		
a. How many people does your Company / Organization employ?	[]	
b. Is cover extended to all Employees?	[] Yes [] No	
 c. Each present full-time and future employees shall be eligible for insurance: □ upon the effective date of the policy. □ upon the date of employment for future employees. □ upon completion of months of continuous service from appointment 	ent.	
	exposures with numbers in each category. & Dependants (including spouse)	
f. Will Eligible Persons contribute towards the cost of this insurance?	[] Yes [] No	
Note: If contributory, at least 90% of employees must sign up unless otherwise stated.		
Are you currently or have you been covered under any Group Medical / Hospitalization and Surgical Insurance Policy? If YES, please provide the following details:		
Policy No. :	Expiry Date :	
Name of Insurer :		
b. Has there been any claims made and if so, how much and how many claims were made for each year for the last 3 years? If there is no Medical Insurance, please indicate Hospitalization Medical Expenses for the last 3 years.		
<u>AMOUNT</u>	NO. OF CLAIMS / CASES	
Year RM	[]	
Year RM	[]	
Year RM	[]	
c. Has an application for medical or hospitalization insurance for your company to be insured than normal terms? [] Yes [] No If YES, please provide details: Note: Please attach a copy of your previous insurance policy wordings and schedule.	ever been declined, postponed or accepted at other	

4. PREMIUM SUMMARY		
CORE BENEFITS		RM
OPTIONAL BENEFITS: 1)		RM
(If any) 2)		RM
3)		RM
TOTAL PREMUIM PAYABLE		RM
ADD GOVERNMENT TAX (5%)		RM
ADD STAMP-DUTY		RM 10.00
ACTUAL PREMIUM PAYABLE		RM
Cheque No. Date:		RM
5. GENERAL GUIDELINES		
I. Employee Group Size a. 20 and below b. 21 to 50 c. 51 and above - Personal Health Declaration and Enrolment Form - Personal Health Declaration (for employee above 40 years old) and Enrolment Form - For quotation purposes, to indicate number of employees under various categories as below:		
Employee Category	Coverage Type	No. Of Employees
Total		
1		
II. Payment All submission must be enclosed with the payment except for group size 51 and above or as specifically agreed by the company.		
DECLARATION		
We hereby apply for a Group Hospitalization and Surgical Plan and declare that to the best of our knowledge and belief the information given herein is true and complete. We agree that if a contract of insurance is effected, all information submitted in connection with this Application shall be the basis of such contract between us and the insurer. Signature of Authorized Officer :		
Name :	Company Stamp	:
VERIFICATION ON AUTHENCITY 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		
[] Photocopy of identity document attached for Individuals with annual premium exceeding RM50,000		
[] Photocopy of Business Registration Certificate for Company with annual premium exceeding RM100,000		
Name of Staff or Intermediary		
New IC No.	Date Sign	nature

NOTE

- This proposal form is for a brief description only. The full details of the plan are to be found in the policy.
- Statement Pursuant to Section 149(4) of the Insurance Act 1996- You are to disclose in this form fully and faithfully all facts you know or ought to know, otherwise the Policy issued hereunder may be void.
- Enrolment age up to 60 years next birthday and any child from 30 days to 19 (if unmarried) or 23 years next birthday (if unmarried & completing tertiary studies).
- Liability is not attached until the proposal has been accepted by the Insurer. 4.
- Any changes in the information given must be reported to the Insurer immediately or else the Insurer will reserve the right to decline all liability. 5.
- 6. Please give a definite answer to each question, dashes are not sufficient. Any question not answered in this proposal will be taken as replied to in the negative.

BRANCHES / CAWANGAN-CAWANGAN:

 BRANCHES / CAWANGAN: Alor Setar (Tel): 04-7305888 (Fax): 04-7305888 (Fax): 04-7305888 (Fax): 07-4326333 (Fax): 07-4323522 (Fax): 03-87338118 (Fax): 03-87343737 (Fax): 03-87343737 (Fax): 03-87343737 (Fax): 03-8734273 (Fax): 03-873