QBE Insurance (Malaysia) Berhad
(Licensed under Financial Service Act 2013, regulated by Bank Negara Malaysia)
Registration No. 198701002415 (161086-D)
SST No. B16-1808-31042744
No. 638, Level 6, Block B1, Leisure Commerce Square,
No. 9, Jalan PJS 8/9, 46150 Petaling Jaya,
Postal Address P.O. Box 10637, 50720 Kuala Lumpur, Malaysia.
Phone: 03-7861 8400 **Fax: 03-7873 7430**
www.qbe.com.my **E-mail : info.mal@qbe.com**

QBE GROUP MEDICAL INSURANCE
PROPOSAL FORM

Policy No: ……..

Account No: ……..……..……..……

IMPORTANT NOTICE

Pursuant to Paragraph 4(1) of Schedule 9 of the Financial Services Act 2013, if you are applying for this Insurance for the purpose of providing medical insurance benefits to your employees and their dependents, you have a duty to disclose any matter that you know to be relevant to our decision in accepting the risks and determining the rates and terms to be applied and any matter a reasonable person in the circumstances could be expected to know to be relevant, otherwise it may result in avoidance of your contract of insurance, refusal or reduction of your claim(s), change of terms or termination of your contract of insurance.

The above duty of disclosure shall continue until the time your contract of insurance is entered into, varied or renewed with us.

You also have a duty to tell us immediately if at any time after your contract of insurance has been entered into, varied or renewed with us any of the information given in this Proposal Form is inaccurate or has changed.

A. DETAILS OF EMPLOYER

1. Name of Employer:

   ……..……..

2. Address:

   ……..……..…

   ……..……...……..

3. Occupation / Trade……..…… Tel: ……..……

4. Period of Insurance: From ___/___/___ to ___/___/___ (dd/mm/yy)

B. CATEGORIES OF INSURED EMPLOYEES

Please give broad categories of occupations/designations of the employees to be insured e.g. clerical, executives, sales officers, engineers, production staff, managers, etc.

No	Category of Occupation	Plan Selected	No. of Employees				
			Employee Only	and Spouse Only	and Children Only	and Family	Total
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
TOTAL							

Please declare separately the full details of the employees and their individual family members to be insured, showing Full Name, Date of Birth, Occupation or Designation (categories as shown above), Sex, Relationship to Employee.

C. ELIGIBILITY OF EMPLOYEES

1. Employees becoming eligible would include those actively at work at the time of application and thereafter all new employees:-

2.
   - ☐ Immediately upon commencement of work i.e. date of employment
   - ☐ On date of confirmation after serving ☐ months probation or as so confirmed by the Management

   Note: If space provided in this proposal form is insufficient, please provide your explanations to the questions on a separate sheet of paper, stating clearly the Question number.

D. PARTICIPATION OF EMPLOYEES

1. Is the Insurance proposed on a non-contributory or contributory basis?

   - ☐ Non-contributory = Premiums borne by the Employer, the persons participating are all i.e. 100% of present and future employees.
   - ☐ Contributory = Premiums borne partially or wholly by the Employee, the persons participating represents at least 75% of present and future employees.
   - ☐ % of the premium payable is borne by the participating employees.

E. MEDICAL & INSURANCE HISTORY

1. Is every employee required to pass a medical examination before being employed?
   YES ☐ NO ☐

2. Have you been previously insured under a similar insurance plan?
   YES ☐ NO ☐

   If YES, please specify Name of Company & Type of Insurance ……..

   If NO, what is your total annual incurred hospitalization expenses? ……...

3. Has the Insurance now proposed been declined, cancelled, refused renewal or subjected to special terms by any Insurance Company? YES ☐ NO ☐

   If YES, please specify Name of Company and details, reasons for such.

   ……

   ……

F. DECLARATION AND SIGNATURE

I/We do hereby declare that:

1. I/We understand that it is my/our duty to take reasonable care not to make a misrepresentation in answering the questions in this Proposal Form and I/we hereby declare that I/we have fully and accurately answered the questions above.
2. I/We hereby authorise, any hospital, surgeon, medical practitioner or clinic or other person who attends to me/Insured Person for any reason to disclose to the insurance 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 authorisation shall be considered as effective and valid as the original..
3. This application and declaration, any medical report, declaration of Insurability or questionnaire completed in connection with the insurance on the employee and/or their family members under the group hereby given shall be the basis of the contract with the Company and I/we will accept the terms, exclusions and conditions which will be set out in the policy to be issued.
4. The liability of the Company does not commence until the application has been accepted.
5. I/We further agree that the Company, it's partners and its related companies, subsidiaries and/or its holding company can share and use my/our data and personal information for the purpose of promoting the Company's and its related companies', subsidiaries' and/or its holding company's products, new services and support requirement; and marketing campaigns and activities and commercial transactions.
   YES ☐ NO ☐

Proposer's Signature:…….. Date: ___/___/___ (dd/mm/yy)
and company stamp