PACIFIC INSURANCE
A member of the Fairfax Group

The Pacific Insurance Berhad (91603-K)
太 平 保 險 有 限 公 司
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PERSONAL HEALTH DECLARATION FORM
(CONSUMER INSURANCE CONTRACT – INDIVIDUAL)

Pursuant to Paragraph 5 of Schedule 9 of the Financial Services Act 2013, if you are applying for this Insurance wholly for yourself/family/dependants, you have a duty to take reasonable care not to make a misrepresentation in answering the questions in this form (or when you apply for this insurance). You must answer the questions in this form fully and accurately. Failure to take reasonable care in answering the questions 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. In addition to answering the questions in this form (or when you apply for this insurance), you are required to disclose any other matter that you know to be relevant to our decision in accepting the risks and determining the rates and terms to be applied. 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 form (or when you applied for this insurance) is inaccurate or has changed.

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Policyholder :			
Occupation :		NRIC No :	
Date of Birth :		Nationality :	
Policy No :		Marital Status :	

2

Name(s) of Insured Person		NRIC or Passport No	Date of Birth	Gender	Height (cm)	Weight (kg)
Insured Person						
Spouse						
Child						
Child						
Child						
Child						

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a. Has any application for medical, disability or life insurance on the Insured Person(s) stated above ever been declined, postponed or accepted at other than normal terms? Yes ☐ No ☐

b. Has the Insured Person(s) above ever made a claim against any insurance company for injury or sickness? Yes ☐ No ☐

If the answer is Yes, please provide the details as follows:

Name of Claimant	Insurance Company	Nature of Disability	Date of Disability	Claim Amount (RM)

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a. Has the Insured Person(s) stated above ever been under continuous medical treatment, undergone surgical operation or advised to do so? Yes ☐ No ☐

b. Has the Insured Person(s) ever had or been treated for any illnesses or condition? Yes ☐ No ☐

If the answer is Yes, please provide the details as follows:

Name of Insured Person	Type of Disability	Date	Duration	Present Condition

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FOR FEMALE ONLY

a. Is the Insured Person now pregnant? Yes ☐ No ☐

b. Is the Insured Person suffering or ever suffered from any disorder of the female organs or periodic pains such that is required medical treatment or any complications in any previous pregnancies? Yes ☐ No ☐

If the answer is Yes, please give the full details.

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When was the last time the Insured Person(s) consulted a doctor and for what purpose? Please state the name and address of the doctor.

DECLARATION AND AUTHORISATION

I hereby declare the above answers are fully complete and true and agree that they shall form part of my insurance cover between the Insured Person and The Pacific Insurance Berhad. I agree to accept The Pacific Insurance Berhad's policy subject to the terms and conditions contained endorsed therein. I hereby authorise The Pacific Insurance Berhad to have access to any medical records held by any doctor, hospital, government institution or insurance company, which relate to my medical history. A photocopy of this authorisation shall be considered as effective and valid as the original.

Date _____ Signature of Policyholder _____