eTiQa Takaful

PERSONAL HEALTH DECLARATION FORM

IMPORTANT NOTICE

1. In accordance with the requirements of Paragraph 5 of Schedule 9 of the Islamic Financial Services Act 2013, you must answer all questions and make the required declarations in this application, and these answers and declarations must be accurate and complete.
2. You must notify Etiqa Family Takaful Berhad in writing should there be a change to any answers or declarations in this application prior to the date of issuance/reinstatement/variation to the coverage.
3. Acceptance of your application shall be subject to underwriting assessment.
4. In this Application Form, unless stated otherwise, the word I and you means Person Covered wherever applicable.
5. All reasonable medical examination expenses incurred in this application will be paid by Etiqa Family Takaful Berhad unless you are informed otherwise by way of written notice from Etiqa Family Takaful Berhad.
6. Please note that it is your duty to take reasonable care not to make a misrepresentation in answering the questions and in making the disclosure.

PERSONAL DETAILS OF MEMBER			
Master Contract No.			
Master Contract Holder			
Full Name of Applicant (Capital Letters)			
Identification Card/Passport No ☐☐☐☐☐☐-☐☐-☐☐☐☐	Date of Birth ☐☐-☐☐-☐☐☐☐	Race: _____	Nationality_____
E-mail Address:		Occupation:	
Staff No.			

Health Declaration			
	Current Height:_____cm **Current Weight:_____kg**		
1	Has your weight changed by more than 5kg in the past one year? If yes, please provide details amount of weight loss / gain, over what period was weight change and reason for weight change.	☐ Yes	☐ No
2	Do you have any Regular / Personal Doctor? If yes, please provide Regular / Personal Doctor Details.	☐ Yes	☐ No
	If yes please provide details in given space below.		
	a. Name, specialty, address and/or telephone number of your personal/usual doctor that you visit most frequently. _____	☐ Yes	☐ No
	b. Date last consulted any doctor and reason. If doctor consulted was not the above named doctor, please also give details of this doctor (name, specialty, address and/or telephone number) _____	☐ Yes	☐ No
	c. Have you consulted a specialist or psychologist in the last 5 years? If yes please give specialist names, specialities, reason for consultations and outcome of visits. _____	☐ Yes	☐ No
3	a) Have you ever had or been told to have or been treated for cancer, tumor, cyst, abnormal lump/growth/swelling, leukemia, melanoma or lymphoma?	☐ Yes	☐ No
	b) Have you ever had or been told to have or been treated for any condition, illness, disease, or disorder, whether medically diagnosed or not, affecting any of the following:	☐ Yes	☐ No
	• cardiovascular system, including the heart, blood, blood vessels, lymph and lymph glands (such as chest pain or breathlessness, palpitations, coronary artery disease, heart attack, heart murmur, hypertension, high cholesterol, anemia, stroke, transient ischaemic attack(TIA)),	☐ Yes	☐ No
	• respiratory system, including lungs, throat and sinuses (such as asthma, bronchitis, pneumonia, tuberculosis),	☐ Yes	☐ No
	• digestive system, including the gall bladder, liver, stomach, esophagus, and bowel (such as ulcers, hepatitis B or C, gastritis or diarrhea lasting for more than a week, jaundice, blood in the stools, colitis, Crohn's disease),	☐ Yes	☐ No
	• mental health or central nervous system, including the brain and nerves (such as epilepsy, convulsions, seizures, fits, blackouts, migraines, severe headaches lasting for more than 12 hours, Parkinson's disease, multiple sclerosis, Alzheimer's disease, paralysis, numbness for a period exceeding a day, involuntary tremors, psychiatric illnesses, dementia, schizophrenia, suicide attempts, nervous breakdown, medically diagnosed depression/anxiety),	☐ Yes	☐ No
	• eyes (excluding refractive eyesight problems corrected by an optometrist) , ears, nose, and speech	☐ Yes	☐ No

	(such as double vision, or nose bleeds which recur at least weekly),	
	• endocrine system, including the thyroid, pancreas, and other endocrine glands (such as diabetes, goiter, pancreatitis, hormone disorders),	☐ Yes ☐ No
	• muscles and bones, including joints (such as gout, arthritis, rheumatism, prolapsed intervertebral disc, physical abnormality, physical dismemberment or disability),	☐ Yes ☐ No
	• urinary or reproductive system, including kidneys, bladder, and urinary tract (such as blood in the urine, abnormal levels of sugar or protein in the urine, kidney stones, and for males, the prostate),	☐ Yes ☐ No
	• skin or immune system (such as eczema, psoriasis, scleroderma, systemic lupus erythematosus (SLE), skin rashes or infections of at least one month, unusual skin lesions).	☐ Yes ☐ No
	c) Have you, your spouse, or partner, ever been told to be tested, diagnosed with, or treated for AIDS, HIV or a Sexually Transmitted Disease (such as herpes, human papilloma virus, syphilis, or gonorrhea)?	☐ Yes ☐ No
	d) Female Only • Are you now pregnant? • Have you ever had during your previous pregnancy/childbirth or do you currently have any pregnancy related complications? • Have you ever had any disease or disorder of the breast, cervix uteri, uterus or ovaries including breast lump, breast or ovarian cyst, carcinoma in situ, fibroid, polyp, abnormal menstrual bleeding?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
	e) In the past 5 years have you ever had or been advised to have or do you intend to undergo any investigations/screening test including blood/urine tests (this includes routine blood screening test done at laboratories/GP clinics), x-ray, ultrasound, CT/MRI scan, calcium score/heart scan, angiogram, echocardiogram, electrocardiogram (resting/stress ECG), pap smear, mammogram, scope, biopsy or predictive genetic test?	☐ Yes ☐ No
	f) Are you currently receiving/considering to seek any medical treatment/advise or in the past 5 years have you ever been referred to or admitted to a hospital or medical facility or ever undergone/been advised to undergo a surgery? If your answer is 'Yes' to any of the above questions, please provide the following details: • question reference, • symptoms (description and dates symptoms presented), • current condition, • diagnosis if any, • medical investigations if any (investigation dates and results), • medication details if any (name, dosage and dates received), • treatment details if any (description, and dates received), and • attending doctor details if any (name, specialty, address, and dates consulted).	☐ Yes ☐ No
	g) Have any of your natural parents and/or siblings, ever suffered from or died as a result of diabetes, cancer, kidney disease, stroke or any other hereditary disease before the age of sixty (60) years? If yes, please provide details of diagnosis, age of onset, current age if living, or age deceased. _____	☐ Yes ☐ No
4	**LIFESTLYE DETAILS**	
	a) Do you currently smoke or have you smoked or used any form of tobacco in the past 12 months? If yes, how many sticks do you smoke per day and how long have you been smoking?_____stick/day_____years	☐ Yes ☐ No
	b) Do you consume beer, wine, spirits or any other type of alcohol or have you ever been treated for alcohol addiction? If yes, please provide details including types of alcohol and average quantity consumed per week (in ml). _____	☐ Yes ☐ No
	c) Have you ever used non-prescribed drugs (non-prescribed drugs includes but is not limited to illegal drugs, recreational drugs, or narcotics)? If yes, please provide details _____	☐ Yes ☐ No
	d) Are you currently participating, or do you intend to participate, in a hazardous occupation, sport or pastime (including but not limited to activities, hobbies and sports such as private aviation, caving, rock climbing,	☐ Yes ☐ No

	diving, horse riding, motorsports, mountaineering, boxing or yachting)? If yes please provide details (including the type of sport, frequency of participation, locations, level of expertise, and any prior accidents or injuries) _____ _____	
5	**EXISTING INSURANCE AND TAKAFUL COVERAGE**	
	1. Have you ever had an application, renewal or reinstatement of a life policy or Family Takaful contract, declined, postponed, rated or subject to special terms, please provide details. Policy or contract include life, Family Takaful, accident, medical, disability, critical illness, or health insurance.	☐ Yes ☐ No
	2. If you have any medical, health or life policy or Family Takaful contracts, with us or any other insurance/Takaful company, please provide details of all inforce policies/contracts and pending applications. If insufficient space, please add an attachment with details on all cover.	☐ Yes ☐ No

Company	Issue Date	Plan	Amount of Coverage Takaful/Insurance

Declaration

Please read carefully before signing this application.

1. I am aware that I must answer all questions, and declarations in this application, and that these answers and declarations are accurate and complete. I agree that failure to answer a question or declaration or, incorrectly answering a question or declaration, may result in termination of the sum covered, a claim not being paid or reduced, or the terms and conditions of the coverage being changed.
2. I agree to notify Etiqa Family Takaful Berhad in writing should there be a change to any answers or declarations in this application, prior to the time that a contract is entered into, varied or renewed of the certificate. I agree that failure to notify Etiqa Family Takaful Berhad of any such change, may result in voidance of the sum covered, a claim not being paid or reduced, or the terms and conditions of the coverage being changed.
3. I confirm that I fully understand that my answers and declarations in this application, and any other relevant documents completed by me in connection with this application and questionnaires, or amendments thereto, shall be relied upon by Etiqa Family Takaful in deciding whether to accept my sum covered or not.
4. I hereby authorise any physician, hospital, clinic, Takaful operator/insurance company, financial institution or any other organisation or company or person that has any records or knowledge about me, my financial standing or my health, to disclose to Etiqa Family Takaful Berhad or its representatives any or all such information about me before or after my death. I agree that a photocopy or facsimile of this authorization shall be considered as effective and as valid as the original and legally binding on anyone who takes over any of my legal rights.
5. Personal Data Protection Act 2010 (PDPA)

   I agree, consent and allow Etiqa Family Takaful Berhad to process my personal data (including sensitive personal data) ('Personal Data') with the intention of entering into a contract of Takaful, in compliance with the provisions of the PDPA.

   I understand and agree that any Personal Data collected or held by Etiqa Family Takaful Berhad (whether contained in this application or otherwise obtained) may be held, used, processed and disclosed by Etiqa Family Takaful to individuals and/or organizations related to and associated with Etiqa Family Takaful Berhad or any selected third party (within or outside Malaysia, including medical institutions, reinsurers, claim adjusters/investigators, solicitors, industry associations, regulators, statutory bodies and government authorities) for the purpose of processing this application and providing subsequent service related to it and to communicate with me/us for such purposes.

   I understand that I have a right to obtain access to and to request correction of any Personal Data held by Etiqa Family Takaful Berhad concerning me. Such request can be made by completing the Access Request Form available at all Etiqa Family Takaful Berhad branches/ or contact Etiqa Family Takaful via email at PDPA@etiqa.com.my. In accordance with the provisions of the PDPA, I may contact the Customer Service Centre at Etiqa Family Takaful Berhad Oneline at 1300 13 8888 for the details of my Personal Data. Such information shall only be granted upon verification.

   Should I not provide an updated bank account for auto credit purposes to Etiqa Family Takaful Berhad (please refer Section B above), I consent that my account with Maybank Group may be utilised for the same purpose.

Signed at _____ day of _____ month _____ year of

Signature of Person Covered

* Signature of Witness
Name :
New NRIC No :

*Witness must be at least 18 years of age and of sound mind.