

GROUP HOSPITALISATION & SURGICAL MEMBER APPLICATION FORM

Etiqa Takaful Berhad ("Etiqa Takaful") is licensed under the Islamic Financial Services Act 2013 to transact both family and general Takaful business in Malaysia and is regulated by Bank Negara Malaysia (BNM).

Before you sign this application form, please read the IMPORTANT NOTICE and if you require, obtain a full and detailed explanation of the notes mentioned in the IMPORTANT NOTICE.

IMPORTANT NOTICE

1. In this application form, unless stated otherwise, the words "I/we, you/your, me/us and my/our" means Participant/Person Covered wherever applicable.
2. 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. You must notify Etiqa Takaful in writing should there be a change to any answers or declarations in this application, prior to the date of issuance of the certificate.
3. You must notify Etiqa Takaful 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.
4. Acceptance of your application shall be subject to underwriting assessment. Cover will commence upon issuance of the certificate.
5. Please ensure that the Takaful Intermediary presents and fully explains the recommended plan in the language that you understand and provides you with the, product disclosure sheet for your consideration. Please seek clarification from the Takaful Intermediary should you not understand any of the terms and conditions therein.
6. Etiqa Takaful does not encourage payment of contribution to the Takaful Intermediary. However if you do pay your contribution through Takaful Intermediary, please ensure you receive Etiqa Takaful's official receipt within a reasonable time but not later than seven (7) days, failing which you should contact Etiqa Takaful. It is important to retain the official receipt as proof of contribution payment.
7. If anyone induces or attempts to induce you to terminate your existing certificate, please report to Etiqa Takaful's Customer Contact Centre immediately.
8. Please provide evidence of age (copy of NRIC or birth certificate) together with this application, as it is a pre-requisite for payment of certificate benefits. If true age is understated, the sum covered/benefits, the bonuses allotted (if any), the contribution or the certificate expiry date may be varied.
9. All reasonable medical examination expenses incurred in this application will be paid by Etiqa Takaful unless you are informed otherwise by way of written notice from Etiqa Takaful.
10. Please contact Etiqa Takaful's Customer Contact Centre if you do not receive the certificate after fourteen (14) business days upon the submission of this application and all supporting documents
11. Please notify the Takaful Intermediary or Etiqa Takaful of any changes in your correspondence address and contact details to enable Etiqa Takaful to effectively communicate with you.
12. If you have an enquiry or require further information, please contact Etiqa Takaful's Customer Contact Centre via e-mail at info@etiqa.com.my or telephone within Malaysia 1300 13 8888. If you have a complaint, dispute or feedback, please contact Etiqa Takaful's Complaints Unit via e-mail at cmu@etiqa.com.my, telephone within Malaysia at 1300 13 8888 or from overseas at +603-2780-4500, facsimile to +603-2785-3093 or by post to Complaints Management Unit, Level 4, Tower C, Dataran Maybank, No. 1 Jalan Maarof, 59000 Kuala Lumpur.
13. A consumer education programme is available on www.insuranceinfo.com.my. If you are dissatisfied with the conduct of Etiqa Takaful, you may refer to Bank Negara Malaysia via e-mail at bnmtelexlink@bnm.gov.my, by calling at +603-2698-8044, by facsimile to +603-2693-4051, or by post to BNMTELELINK, Jabatan LINK & Pejabat Wilayah, Tingkat 13C, Bank Negara Malaysia, P.O.Box 10922, 50929 Kuala Lumpur. If you dispute a decision made by Etiqa Insurance, you may refer to the Financial Mediation Bureau via e-mail at enquiry@fmb.org.my, by calling at +603-2272-2811, by facsimile to +603-2272-1577, or by post to Level 25, Main Block, Menara Takaful Malaysia, No 4, Jalan Sultan Sulaiman, 50000 Kuala Lumpur.

INSTRUCTIONS: Please complete in full and in CAPITAL LETTERS and tick (✓) boxes as appropriate. Use BLACK ink only.

*** Mandatory fields**

A: PERSONAL DETAILS OF PERSON COVERED			
*Master Contract No. / Name of Contract Holder			
Type of Application	<input type="checkbox"/> New Application <input type="checkbox"/> Inclusion of Covered Member		
*Name of Applicant (Capital Letters) as shown in IC			
*Identification Card/Passport No	*Date of Birth	*Race:	*Citizenship
*Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	*Marital Status: :	*Current Height _____cm	/*Current Weight: _____kg
*Mailing Address			Postcode :
*Residential Address (if different from Mailing Address)			Postcode :
*Telephone No. (House) :	Office :	*Mobile :	
*E-mail Address:		*Occupation:	
Coverage/Plan :			
Staff No.			
*Name Employer:		*Nature of Business:	
Business/ Employer Address			Postcode :

Part Time Job (if any)							
B. ACCOUNT NUMBER FOR AUTO CREDIT							
Bank Name							
Bank Account Number							
Bank Branch Address							
* The Applicant's Bank Account must be maintained in Malaysia. In the case of an account outside Malaysia, please make a written request, providing account details to Etiqa Takaful. Etiqa Takaful reserves the right to agree or decline the request, and will advise you in writing. The Applicant must furnish a copy of the bank passbook or bank statement for verification of account details.							
C: FOR PERSON COVERED'S SPOUSE AND CHILD (IF ALSO APPLYING TO BE COVERED)							
Type of Details	Spouse		Child 1				
*Name in Full as shown in IC							
*Identification Card/Passport No							
*Date of Birth							
*Sex							
*Nationality							
*Race							
*Marital Status							
*Current Height and weight	Height: _____ Cm	Weight _____ Kg	Height: _____ Cm	Weight _____ Kg			
*Occupation							
Name Employer							
Nature of Business							
Type of Details	Child 2		Child 3				
*Name in Full as shown in IC							
*Identification Card/Passport No							
*Date of Birth							
*Sex							
*Nationality							
*Race							
*Marital Status:							
*Current Height and weight	Height: _____ Cm	Weight _____ Kg	Height: _____ Cm	Weight _____ Kg			
*Occupation							
Name Employer							
Nature of Business							
D: HEALTH DECLARATION							
			Applicant	Spouse	Child 1	Child 2	Child 3
1	Do you smoke? If yes how many sticks per day and how long have you been smoking? Person Covered : _____ stick(s)/day _____ year(s) Spouse Covered : _____ stick(s)/day _____ year(s)	Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Have you ever had, been diagnosed, or been treated, with an illness/disease/disorder/condition, directly or indirectly related to the following: a) Cancer, tumor, cyst, abnormal lump/growth/swelling, leukemia, melanoma or lymphoma b) Heart, blood vessels, lymph, lymph glands (including coronary artery disease, heart attack, heart murmur, hypertension, high cholesterol, stroke) c) Blood (including anemia, thalassemia, low platelet count, bleeding problems or any other blood disorder) d) Lungs (including pneumonia, tuberculosis) e) Gall bladder, liver, stomach, esophagus, bowel (including hepatitis B or C, blood in the stools, colitis, Crohn's disease) f) Brain, nerves (including epilepsy, convulsions, seizures, fits, Parkinson's disease,	Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	multiple sclerosis, Alzheimer's disease, paralysis, involuntary tremors, psychiatric illness, dementia)	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	g) Thyroid, pancreas, and endocrine glands (including diabetes, goiter, pancreatitis, hormone disorders)	Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	h) Muscles, bones, joints (including gout, arthritis, rheumatism, prolapsed intervertebral disc, physical abnormality, physical dismemberment or disability)	Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	i) Kidneys, bladder, urinary tract (including blood in the urine, abnormal levels of sugar or protein in urine, kidney stones, and for males, the prostate)	Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	j) Immune system (including SLE - Systemic Lupus Erythematosus)	Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	k) HIV, AIDS, sexually transmitted disease (including herpes, syphilis)	Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	l) For males: prostate disease	Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	m) For females: breast, cervix, uterus, ovaries (including breast lump, carcinoma in situ, breast or ovarian cyst, fibroid)	Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	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?	Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	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?	Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	If your answer is "yes" to any of the above questions, please provide the following details: Name of Covered Person:..... Diagnosis..... Date..... Treatment duration:..... Type of treatment:..... Attending doctor particulars:..... Current condition:.....						
6	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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Existing coverage 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, if yes please provide details	Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E: CONSENT FOR MINOR PERSON COVERED (To be completed by the Parent / Legal Guardian if Person Covered is between 30 days and 16 years old age next birthday)

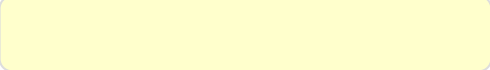
I hereby give my consent for a takaful Certificate to be issued on the life of my child/ward and that he/she is the Person Covered of the takaful Certificate. I consent to the additional declaration to be given by my child/ward in any questionnaires relating to this application.

Name of Parent / Legal Guardian* :

New NRIC:

Old IC/Passport.

Relationship to Child

Signature of Parent / Legal Guardian: 

*Please submit legal documents showing proof as Legal Guardian.

F: DECLARATION / AUTHORISATION AND AQAD

Please read carefully before signing this application.

1. I/We am/are aware that I/we must answer all questions, and declarations in this application, and that these answers and declarations are accurate and complete. I/We 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/We agree to notify Etiqa Takaful 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/We agree that failure to notify Etiqa Takaful 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/We confirm that I/we fully understand that my/our answers and declarations in this application, and any other relevant documents completed by me/us in connection with this application and questionnaires, or amendments thereto, shall be relied upon by Etiqa Takaful in deciding whether to accept my/our application or not.
4. I/We 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/us, my/our financial standing or my/our health, to disclose to Etiqa Takaful or its representatives any or all such information about me/us before or after my/our death. I/We 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/our legal rights.
5. I/We understand and agree that the Takaful coverage I/we have applied for shall only take effect on the date of the TAKAFUL CERTIFICATE HAS BEEN ISSUED by Etiqa Takaful provided always that this application has been approved and that the full contribution has been received by Etiqa Takaful during my/our lifetime and that prior to or as at the date of commencement of the cover, there has been no alterations as to my/our health. If the initial contribution is paid via cheque, I/we understand that the Takaful coverage will only commence after the cheque has been cleared. Commencement Date starts from the contribution deduction month or the inclusion date of the Person Covered, whichever is later.

6. Personal Data Protection Act 2010 (PDPA)

I/We agree, consent and allow Etiqa Takaful 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/We understand and agree that any Personal Data collected or held by Etiqa Takaful (whether contained in this application or otherwise obtained) may be held, used, processed and disclosed by Etiqa Takaful to individuals and/or organizations related to and associated with Etiqa Takaful 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/We understand that I/we have a right to obtain access to and to request correction of any Personal Data held by Etiqa Takaful concerning me/us. Such request can be made by completing the Access Request Form available at all Etiqa Takaful branches/ or contact Etiqa Takaful via email at PDPA@etiqa.com.my. In accordance with the provisions of the PDPA, I/we may contact the Customer Service Centre at Etiqa Takaful Online at 1300 13 8888 for the details of my Personal Data. Such information shall only be granted upon verification.

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

7. APPLICATION OF PRINCIPLES OF TAKAFUL

I/We agree to participate in this Group Takaful scheme based on the principle of Takaful. I/We agree to the concept of Tabarru' (donation) for the purposes of mutual support of other participants and with this contribution, I/we am/are entitled to the Takaful cover as expressed in the terms and conditions of this Takaful contract.

I/We agree to pay the Wakalah Fee (as shown in the Product Disclosure Sheet and as mentioned in the Takaful Certificate) to Etiqa Takaful, as a deduction from contributions, to cover the expenses of managing and distributing the Family Takaful scheme.

I/We understand that at the end of each financial year, the underwriting surplus (if any) from the Participants' Risk Fund (PRF) will be determined by Etiqa Takaful. I/We agree that 50% of the distributed surplus (if any) will be paid to Etiqa Takaful as an incentive for operating and managing the PRF, and the balance of 50% will be shared amongst participants whose certificates have not terminated and who have not made any claim within the financial year.

I/We further agree that if the surplus or any sum payable is less than Ringgit Malaysia Ten (RM10.00) it will be credited into a charity fund which will be utilized as 'amal jariah' on behalf of the participants.

I hereby declare, after reading and understanding the rules pertaining to the Plan above, that I would like to participate in the Plan and agree to abide to the rules of the Plan. I agree to pay RM_____ as contribution for the Plan and consent for _____ to deduct the same amount from my salary.

 Signature of Person Covered
 Date

 Signature of Spouse
 Name :.....
 New NRIC No :.....
 Date

 Signature of Child 1
 Name :.....
 New NRIC No :.....

 Signature of Child 2
 Name :.....
 New NRIC No :.....

Date

Date

Signature of Child 3 (if above 16 years)

Name :

New NRIC No :

Date

*Signature of Witness

Name :

New NRIC No :

Date

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

G: DECLARATION BY TAKAFUL INTERMEDIARY

In this section, "I" refers to the Takaful Intermediary.

1. I hereby declare that the information contained in this application form is the only information given to me by the Person Covered and I have not withheld any other information which might influence the acceptance of this application.
2. In compliance with the Anti-Money Laundering, Anti-Terrorism Financing and Proceeds of Unlawful Activities Act 2001 and Islamic Financial Services Act 2013, I hereby confirm that I have sighted the Person Covered's original NRIC or birth certificate or passport and verified by me at the point of sales.
3. I hereby declare and confirm that I have explained to the Person Covered the information contained in the product disclosure sheet and brochure (where applicable).

Signature of Takaful Intermediary

Name Of Takaful Intermediary :
Takaful Intermediary's Contact No :
Date :

FOR ETIQA TAKAFUL BERHAD'S USE ONLY

Date Received in Head Office:	
Scheme No.	Certificate No.
Monthly Contribution:	
Inclusion Date	Approved Date:
Reviewed by:	