PACIFIC INSURANCE
Wholly-owned subsidiary of PacificMas Berhad

The Pacific Insurance Berhad
Level 5, Menara Prudential, 10 Jalan Sultan Ismail, 50250 Kuala Lumpur
P.O.Box 12490, 50780 Kuala Lumpur
Tel : 03-2176 1188 & 03-2072 6633 Fax : 03-2078 3105

PERSONAL HEALTH DECLARATION FORM

Statement pursuant to Section 149(4) of Insurance Act 1996 : You are to disclose in this Form fully and faithfully all facts which you know or ought to know otherwise the Policy issued may be void.

1. Policyholder :

Occupation :		I C No. :	
Date of Birth :		Nationality :	
Policy No. :		Marital Status :	

2.

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

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

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

   If "Yes", please provide details as follows :

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

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

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

   If "Yes", please provide details as follows :

Name of Person Insured	Type of Disability	Date	Duration	Present Condition

5. **FOR FEMALE ONLY**

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

   b. Is the Person Insured 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 "Yes", please give full details.

6. When was the last time the Person(s) Insured 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 Person Insured and Pacific Insurance Berhad. I agree to accept the Insurer's policy subject to the terms and conditions contained endorsed therein. I hereby authorise the Insurer 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 Employee/Person Insured ____________

Date : ____________ Signature of Employer/Policyholder ____________