From :

To :

LONPAC INSURANCE BHD (307414-T)
LG, 6th, 7th, 21st to 26th Floor
Bangunan Public Bank
No. 6, Jalan Sultan Sulaiman
50000 Kuala Lumpur

POLICY RENEWAL / REPLACEMENT INSTRUCTIONS (COMPULSORY TO COMPLETE)

Insured Person ____________________

Agency Account No. ____________________

NRIC ____________________

Certificate No. ____________________

Plan Insured ____________________

Original Policy No. ____________________

Expiry Date ____________________

Payment Frequency ____________________

☐ Please renew my policy based on the existing terms and conditions and the applicable premium in force on the renewal date.

☐ Please replace my policy with PHM MediSavers 2018 under the following plans :

- ☐ Plan 1 (Room & Board: RM400, Per Disability Limit: RM160,000) With Optional Top-Up Insurance
- ☐ Plan 1 (Room & Board: RM400, Per Disability Limit: RM160,000) Without Optional Top-Up Insurance
- ☐ Plan 2 (Room & Board: RM250, Per Disability Limit: RM100,000) With Optional Top-Up Insurance
- ☐ Plan 2 (Room & Board: RM250, Per Disability Limit: RM100,000) Without Optional Top-Up Insurance

I confirm that I have read the Product Disclosure Sheet and I agree to the following :-

(a) The answers to the questions in the proposal form of my existing policy shall form the basis of the replacement policy
(b) The Takeover Policy Condition shall apply to the replacement policy
(c) All terms, conditions, limitations and specific exclusions of my existing policy shall apply to the replacement policy
(d) The replacement policy shall be subjected to the premium loading (where applicable) imposed on my existing policy

OPTIONAL TOP-UP INSURANCE

If my existing policy is without Optional Top Up Insurance but the replacement policy is with Optional Top-Up Insurance, I declare that the answers to the following questions shall be deem to be added to the basis of the replacement policy

1. Has the person to be insured been hospitalised or surgically treated since the inception of the medical insurance policy with Lonpac Insurance Bhd ? ☐ Yes ☐ No

   If the answer is “Yes”, please provide details below :

DATE OF DISABILITY	DESCRIPTION OF DISABILITY	RESULT OF TREATMENT	NAME OF DOCTOR AND HOSPITAL

2. Has the person to be insured been diagnosed of a new disability since the inception of the medical Insurance policy with Lonpac Insurance Bhd ? ☐ Yes ☐ No

   If the answer is “Yes”, please provide details below :

   Description of Disability ____________________

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.

Signature of Member / Policyholder X ____________________ (Sign Here)

Date ____________________