Gibraltar BSN

HEALTH WARRANTY FORM
Financial Alterations / Reinstatement

Gibraltar BSN Life Berhad (herein after referred to as "the Company / Us / Our") is licensed under the Financial Services Act 2013 and regulated by Bank Negara Malaysia.

Policyowner:

Policy No.: **Life Assured:**

Important Notice :

Consumer Insurance Contract
A "consumer insurance contract" means a contract of insurance entered into by an individual wholly for purposes unrelated to the individual's trade, business or profession

Under Paragraph 5 of Schedule 9 of the Financial Services Act 2013, You are required to take reasonable care not to make any misrepresentation when answering any questions asked by Us i.e. you should answer the questions fully and accurately/correctly. Please note that all the questions that are asked by Us are relevant to Our decision whether to accept the risk or not and the rates and terms to be applied.

If there are any changes to the answers given in the application/proposal form between the time of submission of the application/ proposal form and the time the contract is entered into, You are also required to disclose to us fully and accurately/correctly such changes.

In addition to answering the questions in the proposal form fully and accurately/correctly, You are also required to take reasonable care to disclose to Us fully and accurately/correctly any other matters which You know to be relevant to Our decision on whether to accept the risk or not and the rates and terms to be applied.

If You do not understand Your obligation/duty as stated above or if You need any further explanation, You can contact Us or Our agent.

Non-consumer Insurance Contract
A "non-consumer insurance contract" means a contract of insurance entered into by an individual wholly for purposes related to the individual's trade, business or profession.

Under subparagraph 4(1) of Schedule 9 of the Financial Services Act 2013, You are under a duty to disclose to Us any matter that:

a) You know to be relevant to Our decision on whether to accept the risk or not and the rates and terms to be applied ; or
b) A reasonable man in the circumstances could be expected to know to be relevant. (Collectively referred to as "the material facts").

You are also required to continue to disclose to Us fully and correctly/accurately any material facts which may arise between the time of submission of the application/proposal form and the time the contract is entered into.

You should fully and correctly/accurately answer all the questions in the application/proposal form and any other questions asked by Us.

If You do not understand Your obligation/duty as stated above or if You need any further explanation, You can contact Us or Our agent.

[X] Types of Application

1. ☐ **Inclusion / Upgrading of Supplementary Benefit**	4. ☐ **Increase Term of Basic Plan / Supplementary Benefit / Term Rider**
2. ☐ **Cancellation of Supplementary Benefit**	5. ☐ **Change of Premium (For Investment-Linked Policy only)**
3. ☐ **Increase in Sum Assured of Basic Policy and/or Supplementary Benefit**	6. ☐ **Reinstatement of Policy**

DETAILS OF APPLICATION

1. ☐ Inclusion / Upgrading of Supplementary Benefit

Supplementary Benefit	SA**	Term	Premium

2. ☐ Cancellation of Supplementary Benefit

Supplementary Benefit	Supplementary Benefit

Gibraltar BSN Life Berhad [277714-A]
Level 21, Mercu 2, KL Eco City, No. 3, Jalan Bangsar, 59200 Kuala Lumpur.
Customer Careline: 1-300 22 6262 General Line: 03-2298 2000 Fax: 03-2298 2222
Email: customerservice@gibraltarbsn.com www.GibraltarBSN.com

PPD/10/HW-RFA/092018v1

3. ☐ Increase in Sum Assured of Basic Policy and/or Supplementary Benefit					
Plan / Supp. Benefit	**New SA****	**Premium**	**Plan / Supp. Benefit**	**New SA****	**Premium**

*** SA – Sum Assured*

4. ☐ Increase Term of Basic Plan / Supplementary Benefit / Term Rider					
Plan / Supp. Benefit	**Old Term**	**New Term**	**Plan / Supp. Benefit**	**Old Term**	**New Term**

5. ☐ Change of Premium (For Investment-Linked Policy only)		
New Regular Basic Premium	**New Regular Top Up Premium**	**New Total Regular Premium**

Section A : Lifestyle Details	**Life Assured (LA)**	**Policy Owner (PO)^**
1. Have you smoked any cigarette in the past 12 months? If "Yes", please state number of cigarettes smoked per day [ ] cigarettes smoked per day	☐ Yes ☐ No	☐ Yes ☐ No
2. Do you consume beer, wine, stout, whiskey, brandy or other alcoholic drink? If "Yes", please state the type and quantity per week (number of bottles or glasses or pegs) ? Type [ ] Quantity [ ] bottles / glasses per week	☐ Yes ☐ No	☐ Yes ☐ No
3. Do you intend to engage in any hazardous sports or activities such as diving, racing, mountaineering, rock climbing, gliding, or flying or take part in any aviation activities (other than as a fare paying passenger)? If "Yes", please provide details (type of activity, frequency, location)	☐ Yes ☐ No	☐ Yes ☐ No
4. Have you or your spouse at anytime in the last 3 years resided for more than one continuous month outside Malaysia?	☐ Yes ☐ No	☐ Yes ☐ No
5. Do you have any intention to reside outside Malaysia within the next one (1) year? If "Yes", please provide details such as purpose, country and duration	☐ Yes ☐ No	☐ Yes ☐ No
6. Do you engage in any part time occupation? If "Yes", please provide details (nature of business, exact duty and working hours)	☐ Yes ☐ No	☐ Yes ☐ No
7. Are you a member of any volunteer police or armed forces?	☐ Yes ☐ No	☐ Yes ☐ No

	Life Assured	**Policyowner**
8. What is your present occupation?		

Please give details below :

a. Since? _____ (date)

b. What is your total annual income? RM _____

c. Please describe your occupation and exact duties in details. You may use the space below

Please tick [√] LA / PO. If the answer is "Yes" for any questions from No. 3 to 7, please state the question number and provide details in the box below :

Q. No.	LA	PO	

Section B : Build Details	**Height – cm**	**Weight – kg**	**Gain / Loss of Weight in the past year**
Life Assured			
Policyowner			

Section C : Other Policies Details	Life Assured (LA)	Policy Owner (PO)^
1. Are you insured with the Company or any other life insurance company?	☐ Yes ☐ No	☐ Yes ☐ No
2. Has any of your life insurance policies with us or any other insurance company lapsed in the last 2 years?	☐ Yes ☐ No	☐ Yes ☐ No
3. Is any of your life insurance application for, or reinstatement of existing policy under consideration by us or any other insurance company?	☐ Yes ☐ No	☐ Yes ☐ No
4. Has any of your life / health / accident insurance application or reinstatement of existing policy with us or with any other insurance company ever been declined, postponed, rated-up, restricted or accepted at modified terms?	☐ Yes ☐ No	☐ Yes ☐ No
5. In the past 5 years, has any of your application or reinstatement or renewal of #*Medical and Health Insurance (MHI)* policy with us or with any other insurance company ever been declined, postponed, rated-up, restricted or accepted at modified terms?	☐ Yes ☐ No	☐ Yes ☐ No

 # MHI cover includes but not limited to :
a) medical expense or hospital and surgical or hospital income insurance b) critical illness or dread disease insurance and c) long term care insurance

Please tick [√] LA / PO. If the answer is "Yes" for any questions from No. 1 to 5, please state the question number and provide details in the box below :

Q. No.	LA	PO	Name of Insurer	Type of Insurance	Insurance Details / Year

Section D : Family History	Life Assured (LA)	Policy Owner (PO)^
1. Have any of your parents and / or siblings, living or not, had diabetes, cancer, heart diseases, stroke, hypertension, Down's Syndrome, hepatitis, Alzheimer's disease, Parkinson's disease, motor neuron disease, Huntington's disease, muscular dystrophy, polycystic kidney disease, cystic fibrosis, etc.? If "Yes", please provide details below.	☐ Yes ☐ No	☐ Yes ☐ No
2. Has your spouse, living or not, had any sexually transmitted disease, AIDS Related Conditions or been tested HIV positive? If "Yes", please provide details below.	☐ Yes ☐ No	☐ Yes ☐ No

Family Member (Specify Relationship)	Medical Condition(s) / Diagnosis	Age at Diagnosis	Age at Death (if applicable)

Section E : Health Details		
I / We hereby expressly declare the following :	**Life Assured (LA)**	**Policy Owner (PO)^**
1. Have you ever used illegal or recreational drugs or narcotics, or habit forming drugs, or been treated for alcoholism or drug habit/addiction?	☐ Yes ☐ No	☐ Yes ☐ No
2. Are you on any form of medication at present (other than for normal fever, cough, flu)? If "Yes", state reason and type of medication below	☐ Yes ☐ No	☐ Yes ☐ No
3. Have you EVER had or been told you had or been treated for or currently have :		
a. Epilepsy, fainting spells, seizure, nervous or mental conditions, neuritis, paralysis or any disease or abnormality of the brain or nervous system?	☐ Yes ☐ No	☐ Yes ☐ No
b. Giddiness, loss of consciousness, breathlessness, chest pain, palpitation, heart attack, hole in the heart, high blood pressure, raised cholesterol, rheumatic fever, valvular heart disease, heart murmur, deep vein thrombosis, any disease of the heart, blood vessel or blood (e.g. anaemia, thallasaemia, hemophilia) ?	☐ Yes ☐ No	☐ Yes ☐ No
c. Blood spitting, tuberculosis, pneumonia, bronchitis, bronchopneumonia, asthma, habitual or prolonged cough, pleurisy, emphysema or any respiratory or lung disease?	☐ Yes ☐ No	☐ Yes ☐ No
d. Recurrent indigestion, gastritis, irritable bowel syndrome, ulcer or polyp in the stomach, hernia, fistula, piles or any disease of gall-bladder, pancreas, stomach or intestine?	☐ Yes ☐ No	☐ Yes ☐ No
e. Sugar or blood or protein in the urine, kidney or bladder stones, enlarged prostate, venereal disease (eg. gonorrhea, syphilis, genital sores or discharges), kidney failure, polycystic kidney disease or any disease of kidney, prostate, urinary or genital system?	☐ Yes ☐ No	☐ Yes ☐ No

f. Diabetes, abnormal blood sugar level, goitre, hyperthyroidism, hypothyroidism or any disease or abnormality of the thyroid or other endocrine glands (pituitary, adrenal, pancreas, testes)?	☐ Yes ☐ No	☐ Yes ☐ No
g. Blindness, impaired sight, cataract, detached retina, deafness, hearing difficulty requiring hearing aid, mutism, tonsilitis or any disease of the eyes, ears, nose or throat?	☐ Yes ☐ No	☐ Yes ☐ No
h. Leukaemia, Hodgkin's disease, lymphoma, brain or spinal tumour, or any type of cancer, tumour, cyst or growth?	☐ Yes ☐ No	☐ Yes ☐ No
i. Jaundice, hepatitis, hepatitis B carrier, hepatitis C carrier or any disease of the liver?	☐ Yes ☐ No	☐ Yes ☐ No
j. Rheumatism, arthritis, gout, osteoarthritis, osteoporosis, bone fractures (with or without implants), backache, slipped disc, or any disease of the spine, bones, joints, muscle, connective tissue, lymph nodes or spleen?	☐ Yes ☐ No	☐ Yes ☐ No
k. Systemic lupus erythematosus, facial skin rashes, psoriasis, leprosy or eczema?	☐ Yes ☐ No	☐ Yes ☐ No
l. Polio, paralysis or any other physical impairment, congenital abnormalities / conditions or hereditary disorder (such as Alzheimer's disease, Parkinson's disease, motor neuron disease)?	☐ Yes ☐ No	☐ Yes ☐ No
4. Have you ever been hospitalised or undergone any surgical operation or observation or treatment or been advised to seek any medical or surgical consultation or follow up?	☐ Yes ☐ No	☐ Yes ☐ No
5. Have you ever received blood transfusion, treatment with human blood products or received a donated organ or refused as a blood donor?	☐ Yes ☐ No	☐ Yes ☐ No
6. Have you ever received any medical advice, counseling or treatment in connection with AIDS, AIDS Related Complex or any other AIDS related conditions; OR have you had HIV testing done (please state result), OR in the last 3 months had any of the following symptoms for more than one week continuously: fatigue, weight loss, diarrhoea, enlarged lymph nodes or unusual skin lesions?	☐ Yes ☐ No	☐ Yes ☐ No
7. In the PAST 5 YEARS, have you had any diagnostic tests such as blood or urine tests, X-ray, mammogram, biopsy, electrocardiogram (ECG), CT scanning, echo or ultrasound or been advised to have any of these in the future?	☐ Yes ☐ No	☐ Yes ☐ No
8. Has your weight increased or decreased by more than 5 kg (11 lbs) in the past 2 years? If "Yes", please state reason below	☐ Yes ☐ No	☐ Yes ☐ No
9. For Female applicant only		
a. Have you ever had, or received any treatment for, or intend to be treated or consult a physician for:		
i. Ovarian cyst, abnormal uterine or vaginal bleeding, abnormal enlargement of abdomen, fibroid, polyp, carcinoma in situ, cancer or growth or any disease or disorder of the breasts or female reproductive organ?	☐ Yes ☐ No	☐ Yes ☐ No
b. Have you ever had :		
i. an abnormal mammogram or been advised to have an ultrasound of the breast, cone biopsy or colposcopy?	☐ Yes ☐ No	☐ Yes ☐ No
ii. A Pap Smear, which you were advised to repeat within 6 months, or were found to be abnormal?	☐ Yes ☐ No	☐ Yes ☐ No
iii Pregnancy complications during gestation and / or delivery/ies? (e.g. ectopic pregnancy, disseminated intravascular coagulation, diabetes, hypertension, still birth, etc.)	☐ Yes ☐ No	☐ Yes ☐ No
iv Any test or intend to do any test to exclude or determine Down's Syndrome during gestation or any other genetic testing?	☐ Yes ☐ No	☐ Yes ☐ No
c. Are you now pregnant? If 'Yes', how many months? [ ] months	☐ Yes ☐ No	☐ Yes ☐ No
10. FOR CHILD BELOW 2 YEARS OF AGE ONLY :		
a. Is the child born premature or pre-term (less than 36 weeks)?	☐ Yes ☐ No	☐ Yes ☐ No
b. If the answer to question 10 a is "Yes", please proceed with below questions i), ii) and iii) and provide us a copy of the Child Health Book.		
Please specify months [ ] Months [ ] Weeks		
What was the baby's birth weight? [ ] KG [ ] Grams		
Specify the duration of hospital stay of baby after birth [ ] No of Days		

^To be completed when Policyowner applies for Payor Benefit Rider(s) OR Reinstating policy with Payor Benefit Rider(s)

Please tick [√] LA / PO. If the answer is "Yes" for any questions from No. 1 to 10, please state the question number and provide details in the box below :

Q. No.	LA	PO	

Notice:
Please note If you are a NON-MUSLIM and your nominee named is your spouse, child or parent (where there is no existing spouse or child at the time of nomination) your policy, upon issuance by Gibraltar BSN Life Berhad, becomes a trust policy. Thereafter you are not permitted to revoke your nomination, make financial variation, surrender, assign or pledge the policy as security, without the consent of the trustee(s). If trustees are not appointed the following may becomes the trustees:

a. the nominee who is competent or
b. where the nominee is incompetent, the parent of the incompetent nominee and where there is no surviving parent, the Public Trustee.

Personal Data

i. Personal Information may include Policyowner and / or Life Assured name, identification number, address, phone number, email address as well as non public information including details of condition or history of medical, health and hospitalization, financial, familial and non-familial information and any updated information of the same for the applicable product or service.
ii. Gibraltar BSN Life Berhad shall not disclose the Personal Information without prior consent of the Policyowner.
iii. The Policyowner has the right to access his Personal Information and shall be allowed to make any update or correction through a written request to the Company and the Company has the right to impose a fee for this purpose.
iv. Gibraltar BSN Life Berhad shall take reasonable steps to protect the Personal Information from any unauthorized access or misuse and in ensuring accuracy of the Personal Information at all times and shall not keep the Personal Information longer than necessary for the purpose of this application and maintenance of the Policy Contract.

Declarations

Personal Data
I hereby give consent to the following for the purpose of processing this form :

a) to Gibraltar BSN Life Berhad to hold, use or disclose my Personal Information to any hospital, clinic, physician, specialist, insurance or reinsurance companies, professional adviser or bodies, Life Insurance Association of Malaysia, Financial Mediation Bureau, Insurance Services of Malaysia, organization, institution or person(s) and authorized agents or representatives.
b) to any hospital, clinic, physician, specialist, insurance or reinsurance companies, professional adviser or bodies, Life Insurance Association of Malaysia, Financial Mediation Bureau, Insurance Services of Malaysia, organization, institution of person(s) and authorized agents or representatives to hold, use or disclose my **Personal Information to Gibraltar BSN Life Berhad and/or its authorize representatives.

For Investment Linked Policies only (Inclusion of Supplementary Benefits)
AUTHORISATION TO CHARGE PREMIUM OF SUPPLEMENTARY CONTRACT(S) TO ACCOUNT VALUE
I, the Policyowner / Life Assured under the above mentioned Policy, hereby instruct Gibraltar BSN Life Berhad, upon approval of the abovementioned Application, and subject to the terms and conditions of the policy to charge the Account Value automatically for the premium of the supplementary contract(s) applied herein on the Supplementary Benefit (Rider) Commencement Date and on each monthly anniversary of the Commencement Date thereafter and whilst the policy is maintained in force in accordance with the Premium Holiday provision of the policy.

Financial Alterations / Reinstatement / Redating of Policy
I hereby in my capacity as

- the Life Assured
- the Policyowner, Legal Guardian of the Life Assured who is a minor
- the authorized person to endorse this application on behalf of the Policyowner (Policyowner is a Corporate Body)

hereby declare that :

a) I am aware that it is my pre-contractual duty of disclosure that I must exercise reasonable care not to misrepresent i.e. to give false answers / information when answering any questions asked by the Company and that I am to answer the questions fully and accurately/correctly;
b) I have read and understood the contents of the application form including all warnings and notices therein and I have fully and accurately answered all the questions in the application form and the other questions asked by the Company, if any, after having fully read and understood the questions.
c) I am aware that I must inform the Company of any change to the answers given in the Application Form if the change occurred after I have submitted the application form but before the Contract is entered into
d) I fully understand that my answers and/or statements given in respect of the questions asked by the Company, and any other relevant documents completed by me in connection with the application and in any medical report or amendments (collectively referred to as “the information”) are relevant to the Company in deciding whether to accept my application or not and the rates and terms to be applied;
e) I am aware that if any of my answers or statements or information given by me is not accurate/ correct, the Policy may be avoided, my claim denied or reduced, the terms of the Policy changed or varied, or the Policy terminated.
f) I understand and agree that the insurance coverage applied for shall not take effect unless and until written acceptance of this offer is communicated by the Company during my lifetime and good health
g) The Sales Intermediary/Agent has explained the essential information on the major features of the product(s) selected above to my satisfaction. I have given to the Sales Intermediary / Agent no other information, except as written in this application
h) the suicide clause shall recommence as of the approval date of this application (reinstatement effective date) and where the supplementary rider(s) applied above expressly state a ‘waiting period’ before a claim could be considered, such ‘waiting period’ shall take effect from the effective date of the notice of reinstatement issued thereunder.

Signed at _____ this _____ day of _____ 20_____

Signature of Policyowner / Life Assured	**Signature of Parent**	**Signature of Witness**
Name:	**Name:**	**Name:**
Date:	**Date:**	**NRIC No.:**
		Date:

Trustee Consent
I/We, the Trustee(s) / Assignee(s), hereby give my/our consent to the said financial alteration(s) requested.

Signature of Trustee / Assignee	**Signature of Trustee / Assignee**	**Signature of Witness**
Name:	**Name:**	**Name:**
Date:	**Date:**	**NRIC No.:**
		Date: