LONPAC INSURANCE BHD 199401021735 (307414-T)

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APPLICATION FORM
OPTIONAL ADVANCED OUTPATIENT CANCER TREAMENT BENEFIT

Product / Plan : MediSaversVIP Prime / As per Section A (Basic Coverage)

Name of Proposer/Policyholder : _____

NRIC/ID No. of Proposer/Policyholder : _____

Name of Person to be Insured/Insured Person : _____

NRIC/ID No. of Person to be Insured/Insured Person : _____

Existing Policy No. (where applicable) : _____

Health Questionnaire

1. State the Height and Weight of the Person to be Insured.

   Height: _____ (cm) Weight: _____ (kg)

2. Has any of the Person to be Insured's first-degree relative (biological parents, siblings and children) suffered or died from Cancer? ☐ Yes ☐ No

   If "Yes", kindly state the number of first-degree relative suffered or died from Cancer. _____

3. Is the Person to be Insured a recipient of organ transplant(s) or stem cell transplant? ☐ Yes ☐ No

4. Has the Person to be Insured ever had, or been told to have, or is currently under investigation for any of the conditions below? ☐ Yes ☐ No
   - Cancer (including Leukaemia, Lymphoma or Melanoma)
   - Carcinoma in situ of any kind
   - Tumour, cyst, growth, lump, or nodule
   - Hepatitis B/C, Liver Cirrhosis, or Liver disease due to alcohol
   - Epstein-Barr Virus (EBV) infection
   - Human Papillomavirus (HPV) infection
   - Human T-Cell Leukemia/Lymphoma Virus Type 1 (HTLV-1) infection
   - Kaposi Sarcoma-Associated Herpesvirus (KSHV) infection
   - Merkel Cell Polyomavirus (MCPyV) infection
   - Helicobacter Pylori (H. Pylori) infection
   - Barrett's Oesophagus
   - Crohn's Disease
   - Ulcerative Colitis
   - HIV or AIDS
   - Raised Tumour Marker(s)

5. In the past three (3) months, has the Person to be Insured ever experienced any of the conditions listed below? ☐ Yes ☐ No
   - Unexplained weight loss of five (5) kg or more
   - Blood in urine
   - Prolonged coughing for more than two (2) weeks
   - Bleeding from the bowels or in stools
   - Diarrhoea or constipation for thirty (30) days or more

Declaration

I/We as the Policyholder/Proposer agree to apply for the Optional Advanced Outpatient Cancer Treatment Benefit and agree to pay an additional premium as specified by Lonpac Insurance Bhd.

I/We are fully aware and understand that the following Specific Conditions in relation to the Optional Advanced Outpatient Cancer Treatment Benefit shall apply to my/our policy:

- Treatment rendered must be deemed Medically Necessary, proven effective according to established local, regional, and international medical standards and duly approved by the National Pharmaceutical Regulatory Agency of Malaysia and/or the Ministry of Health, Malaysia at the time such treatment is rendered. Experimental, investigational, research, preventive, and/or screening treatments are excluded.

- Notwithstanding the exclusion of Pre-existing Conditions, this benefit will not be payable for any Insured Person who had been diagnosed as a Cancer patient and/or is receiving Cancer treatment prior to the date this benefit is first covered.

- This benefit shall not cover any claim whereby the signs and/or symptoms first occur within the first one hundred and twenty (120) days, from the date this benefit is first covered.

- Surveillance or prevention of Cancer shall not be covered.

I/We further understand and agreed that:

- It is my/our duty to take reasonable care not to make a misrepresentation in answering the questions in this Application Form and I/We hereby declare that I/We have fully and accurately answered the questions in this Application Form.

- Completion of this form shall not be construed as acceptance of my/our application until it is approved by Lonpac Insurance Bhd and full premium is paid and received by Lonpac Insurance Bhd.

I/We agree to the following (where applicable):

- The answers to the questions in the Proposal Form of my existing policy shall form the basis of the replacement policy,
- The Take-Over Policy Condition shall apply to the replacement policy,
- All terms, conditions, limitations, and specific exclusions of my existing policy shall apply to the replacement policy, and
- The replacement policy shall be subject to the premium loading imposed on my existing policy.

I/We hereby authorise Pathlab Health Management (M) Sdn. Bhd., any hospital, surgeon, medical practitioner, clinic and/or other person who attends to me/us/Insured Person for any reason to disclose to the Company any and all information with respect to any illnesses or injury and to provide copies of all hospital or medical records/certifications, including any earlier medical history to the Company. A photocopy of this authorisation shall be considered as effective and valid as the original.

_____ Date (dd/mm/yyyy)

_____ Signature of Proposer/Policyholder