Allied Risk Solutions Sdn Bhd (587784-M)

Group Hospitalisation & Surgical Declaration Form

Policy Holder : _____

Policy No. : _____

Date : _____

Insured No.	Employee's or Dependent's Name (as per I/C)	Date of Birth			NRIC / Passport No./ Birth Cert. No.	SEX	Relationship E- Employee H-Husband W-Wife C-Child	Occupation	Effective Date			A-Addition D-Deletion C-Change	Plans	* Please give details of all known Physical Abnormalitities and current medical disabilities	* Signature of Applicant (by Parent if Applicant is a MINOR)
		Date	Mth	Yr.					Date	Mth	Yr.				

Note :

For Deletion - Require name, Insured No. and effective date only.

PURSUANT TO SECTION 16 (4) OF THE INSURANCE ACT, 1963 you are to disclose in this proposal form, fully and faithfully all the facts which you know or ought to know, otherwise this Policy isuued hereunder may be void.