MELLITA CARE
PROPOSAL FORM

Application Date

DD/MM/YY

Archipelago™
Life Insurance Limited

Archipelago Life Insurance Limited
Co. No. LL09829

(A Life Insurer Licensed by Labuan FSA)
Licence Bo. IS2013141

INSTRUCTIONS

1. Please complete the form in CAPITAL LETTERS. All fields are mandatory. Use blue/black ink only.
2. Please indicate all options selected with an [X].
3. Please initial any amendments made.
4. Please submit completed set of documents in the checklist below.

- ☐ Completed Mellita Care proposal form
- ☐ Completed Mellita Care Attending Physician Statement.
- ☐ Proof of Income Documents
  - a. For individual - EA Form or latest 3 months salary slip
  - b. For Corporate - Latest Financial Statement
- ☐ Original or certified copy of following medical reports:
  - ☐ Medical examination
  - ☐ MU (Microscopic Urinalysis)
  - ☐ ECG (Electrocardiogram with reporting/interpretation)
  - ☐ HIV (Elisa Test for HIV Antibody)
  - ☐ Blood Profile1
  - ☐ Any other relevant medical report(s)
- ☐ Photocopy of
  - a. For Individual – NRIC or valid passport; or
  - b. For Corporate – Memorandum & Articles, Form 24 & 49, company registration certificates
- ☐ For Corporate – A set of Board of Directors' Resolution / Mandate
- ☐ Photocopy of life assured's NRIC or valid passport (if different from proposer/owner)

5. Archipelago Life Insurance Limited will only process this application when all required documents are received and reserves the right to reject any application which is deemed incomplete.

NON DISCLOSURE

You and/or the Life Assured must disclose all material facts you and/or the Life Assured know or ought to know which may affect the insurance coverage.

We reserve the rights to avoid entering into the contract if you and /or the Life Assured fail to disclose any material fact required.

Note: The acceptance of this proposal form by us is not itself a warrant to enter the insurance contract. We reserve the rights to consider the insurability of the Life Assured, thereafter not be liable in any way to any cost may incur directly or indirectly by any other party as a result of or in connection with this application.

A. CHOOSE YOUR PLAN

- ☐ Standard Plan (Death Benefit : USD 50,000 with an Accelerated Critical Illness : USD 50,000)
- ☐ Select Plan (Death Benefit : USD 100,000 with an Accelerated Critical Illness : USD 100,000)
- ☐ Elite Plan (Death Benefit : USD 200,000 with an Accelerated Critical Illness : USD 200,000)

B. WELLNESS PROGRAM

Diabetic Wellness Program ☐ Yes ☐ No

If yes, please provide the following details :

Name of hospital / Medical Centre ______________________

Name of Wellness Plan ______________________

C. DETAILS OF LIFE ASSURED

Salutation : Mr / Mrs / Miss / Tan Sri / Dato' / Dr. / Ir. / (Others, pls state) :		
Full Name (As per NRIC/Passport, pls underline surname) :		
Date of Birth : DD/MM/YYYY		Nationality :
NRIC / Valid Passport No :		Country Issue :
Gender : ☐ Male ☐ Female		
Marital Status : ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Correspondence Address :		
		Postal Code :
Permanent Address : (If same as above, tick here ☐)		
		Postal Code :
Occupation and Industry :		Exact Duties :
Company Name :		
Company Address :		
Contact No :	Mobile No :	Email :
Annual Income: USD ☐☐,☐☐☐,☐☐☐		

D. DETAILS OF PROPOSER / POLICYHOLDER

☐ Please tick this box; if the Proposer/PolicyHolder and the Life Assured are the same person (skip to Section E).

Salutation : Mr / Mrs / Miss / Tan Sri / Dato' / Dr. / Ir. / (Others, pls state) :		
Full Name (As per NRIC/Passport, pls underline surname) :		
Date of Birth : DD/MM/YYYY		Nationality:
NRIC / Valid Passport No :		Country Issue:
Gender : ☐ Male ☐ Female		Relationship with Life Assured :
Correspondence Address :		
		Postal Code :
Permanent Address : (If same as above, tick here ☐)		
		Postal Code :
Contact No :	Mobile No :	Email :

E. CONTINGENT OWNER

(The Contingent Owner will be the owner of the policy if the Policyholder deceases before the Life Assured)

Salutation : Mr / Mrs / Miss / Tan Sri / Dato' / Dr. / Ir. / (Others, pls state) :	
Full Name (As per NRIC/Passport, pls underline surname) :	
NRIC / Valid Passport No :	Country Issue:

F. DETAILS OF CORPORATE

Type of Business Entity : ☐ Sdn Bhd / Pte Ltd	☐ Others	
Entity Name :	Entity Registration Number :	
Business Address :		
	Postal Code :	
Correspondence Address: (If same as above, tick here ☐)		
	Postal Code :	
Telephone :	Fax No. :	Mobile No. :
Authorised Contact Person :		

G. RISK ASSESSMENT

1. Do you have any current Insurance in force (e.g. Life, Critical, Medical, Health, Total Permanent Disablement, and Personal Accident) and application(s) pending with us or other Insurers for Life Assured? If yes, please specify :	☐ Yes	☐ No

Name of Insurer	Type	Sum Assured

2. Has any of your applications, renewal or reinstatement for life, critical illness, personal accidental or medical/ health insurance policy ever been Postponed/Declined/Modified or accepted at other than normal terms by this or other insurance companies?	☐ Yes	☐ No
3. Have any life / medical insurance claims ever been submitted?	☐ Yes	☐ No
If yes, please specify the amount and year of claim :		

4. Please complete the following fields :	Height : cm	Weight : Kg	BMI : Kg/M²
5. What is your last known fasting blood glucose level?	Date :	HbA1c (%)	mmol/mol

6. What is your last known usual blood pressure? Date :

	First Reading (mmHg)	Second Reading (mmHg)	Third Reading (mmHg)
Systolic BP			
Diastolic BP			

7.	What is your last known usual cholesterol level? Date :

(Please circle the unit)

Total Cholesterol		mg/dl or mmol/l or g/l
Triglycerides		mg/dl or mmol/l or g/l
LDL Cholesterol		mg/dl or mmol/l or g/l
HDL Cholesterol		mg/dl or mmol/l or g/l

8.	What is your Proteinuria level?		
9.	Have you had any medical emergency due to diabetes? If yes, please specify :	☐ Yes	☐ No

H. LIFESTYLE

1.	Do you consume alcohol?	☐ Yes	☐ No
	If yes, please specify the numbers of drinks per week :		
2.	Have you smoked tobacco or any other substance or used any nicotine-containing product before?	☐ Yes	☐ No
	If yes, please specify what type and how many sticks/day?		

I. MEDICAL QUESTIONNAIRE

Item	Question	Yes	No
1	Are you currently receiving medical treatment and/or suffering from physical impairment, congenital abnormality or poor health?		
2	Depression, fatigue, anxiety, stress, eating disorder or any other psychological disorders?		
3	High blood pressure, high cholesterol, deep vein thrombosis or irregular heartbeat?		
4	Chest pain, palpitations, angina pectoris, disease of the heart or heart attack?		
5	Headache, Numbness of the face, arm or leg and trouble with seeing?		
6	Fluid build-up, loss of sleep, poor appetite, upset stomach, difficulty concentrating?		
7	Varicose veins or venous ulcers?		
8	Abnormal blood test, leukaemia, enlarge lymph nodes, rheumatic fever, severe skin disease, anaemia, or other blood disorder?		
9	Cancer, benign tumours, growths, cysts or moles that have changed in appearance?		
10	Neurological disorder including migraines, recurrent headaches, epilepsy, multiple sclerosis or ME?		
11	Disease or disorders of the liver, pancreas, gallbladder, stomach, bowel or intestines?		
12	Jaundice, Hepatitis, Hepatitis B carrier, Hepatitis C carrier?		
13	Disease or disorders of the prostate, urinary system, kidney or bladder?		
14	Persistent protein or blood in the urine, kidney stones or diseases of urinary system?		
15	Glandular disorder including diabetes, breast cysts or lumps, thyroid or hormonal problems?		
16	Asthma, tuberculosis, chest infections, bronchitis, COPD, cystic fibrosis or any lung diseases?		
17	Tonsillitis, sinusitis, cataracts, deafness or any other ear, nose, throat or eye problems?		
18	In the past 5 years, have you undergone any one/more diagnostic test, including but not limited to X-ray, electrocardiogram, blood study, mammogram, ultrasound or biopsy? If yes, please submit a copy of the result.		

Item	Question	Yes	No
19	**FEMALE ONLY** A. Are you currently pregnant?		
	B. Complications of pregnancy and childbirth, ovarian cysts, heavy or irregular periods, fibroids, endometriosis, infertility or abnormal smear tests?		
20	**FAMILY RELATED** A. Have any of your immediate family members (father, mother, sister, brothers) ever suffered from or died as a result of diabetes, heart diseases, stroke, cancer or any hereditary disease before age of 60 years?		
	B. Have you or your spouse ever received any medical advice, been tested for HIV or treated for AIDS, AIDS related complex?		
21	Is there any other information or exceptional circumstance pertaining to your health not disclosed above and which would be material to the acceptance of this application?		
22	Experience any end organ damage: Left Ventricular hypertrophy, Hypertensive, Nephropathy, Hypertensive Retinopathy, Retinopathy, Neuropathy, Nephropathy.		

Item	**Symptom / Medical condition**	**When did it start?**	**What treatment did you receive and when? (Please include dates and any medication prescribed)**	**What was the outcome of the treatment? (Eg. ongoing, still under review, complete recovery, recurrent or likely to recur?**

J. REGULAR / FAMILY DOCTOR'S DETAILS

1. Please provide the name and address of your usual doctor who treated you or your family.

Doctor's Name :		
Medical Centre / Clinic :		
Address :		
Contact No :	Mobile No :	Email :
2. How long have you been using the services of this Doctor's / Medical Centre?		years

K. BENEFICIARY NOMINATIONS

(ONLY applicable if the policyholder and life assured are the same natural person)

Beneficiaries for Proceeds

- Beneficiary (ies) is (/are) only entitled to the benefit upon death of the Life Assured.
- You may nominate one or more beneficiaries under this policy. Please ensure you provide NRIC/passport no of the beneficiary (ies); otherwise the Nomination of beneficiary (ies) will not be accepted.
- You may change the beneficiaries appointed in this application by notifying Archipelago Life Insurance Limited in writing and which must be received before death of the Life Assured.
- If no beneficiary is nominated, the executor of your estate will advise Archipelago Life Insurance Limited of the natural person(s) entitled to receive the proceeds, failing which the proceeds may be payable to your estate subject to the requirements of the regulatory authority and/or legislation.
- In accordance with the Labuan Financial Services and Securities Act 2010 (LFSSA 2010) :
    - Section 121 – It states that a nomination by a policy owner, other than a Muslim policy owner, shall create a trust in favour of the nominee of the policy monies payable upon the death of the policy owner IF the nominee is a spouse or child of the policy owner, or where there is no spouse of child living at the time of nomination, the nominee is the parent. A payment under this section shall NOT form part of the estate of the deceased policy owner or be subject to his/her debts; OR
    - Section 122 – It states that a nominee, other than a nominee under Section 121, shall receive the policy monies payable on the death of the policy owner as an executor and not solely as a beneficiary and any payment to the nominee shall form part of the estate of the deceased policy owner and be subject to his debts. This section also applies to a nominee of a Muslim policy owner who, on receipt of the policy monies, shall distribute the policy monies in accordance with Shariah principles.

Full Name (please underline Surname)	Relationship to Life Assured	NRIC / Passport No.	Shares of benefits %
		TOTAL	**100%**

- If there are additional beneficiaries, please attach the above information on a separate Beneficiary Nomination Form.
- Please ensure the total percentages nominated are equal to 100%.

Appointment of Trustee

- The policy owner may appoint an individual or Corporate Trustee for the policy monies.
- Where no Trustee is appointed, the nominee who is competent to contract, or where the nominee is incompetent to contract, the parent of the incompetent nominee, and where there is no surviving parent, the Public Trustee shall be the trustee of the policy monies.

Name of Trustee	Individual or Corporate	NRIC / Passport No. / Company Reg. No.

L. PERSONAL DATA PROTECTION ACT 2010

1. Archipelago Life Insurance Limited (“Insurer”) undertakes that all personal data acquired from the Insurer from the application date shall only be used strictly for the purposes of this Endowment Policy.
2. Any information and data provided by the policyholder to the Insurer and by the Insurer to the policyholder and used by the Insurer directly or indirectly in the context of this Insurance Policy shall be governed by the provisions in the Personal Data Protection Act 2010 (herein referred to as ‘the Act’).
3. The Insurer will use any personal data to process your claims, administer your plan, service our relationship with you, provide you with products and services and evaluate their effectiveness, provide you with better customer service and for statistical analysis.
4. The policyholder consents to the processing of the personal data provided to the Insurer and to the transfer of such personal data to other entities for the purposes of performance of the contract. Such personal data shall be governed by the personal data protection laws of that country.

5. The policyholder is responsible to ensure that all data provided to the Insurer are accurate at all times and is obliged to inform the Insurer of any changes. You may request for access to, correction, or deletion of your personal information or limit the processing thereof at any time hereafter.
6. Your information may also be used for fraud prevention and audit purposes. If you give us false or inaccurate information and we suspect fraud, we will record this. We may pass such information to the law enforcement or other legal agencies, government or judicial bodies, or to regulators.
7. We may, from time to time, provide you with marketing information about Archipelago Life Insurance Limited, our products and services and those associated companies which may be of interest to you. If you do not want us to use your details in this way, please tick the box ☐ .

M. PAYMENT DETAILS

Card

We can accept card payments by Visa or MasterCard. Please complete the Credit card authority attached to this application. Please make sure that your card is valid for at least three months from the start date of your plan.

Bank Transfer

Bank transfer must be in United States Dollar (USD). Please make sure that you give your full name and quotation or plan number as the reference for your bank transfer. Please send your payment to 'Archipelago Life Insurance Limited' and to the corresponding details below.

US dollar ($) Account	
Beneficiary :	Archipelago Life Insurance Limited
Banker :	Alliance Bank Malaysia Berhad
Address :	Unit A-0G-02, Block A, Plaza Mont' Kiara, 2 Jalan Kiara Mont' Kiara, 50480 Kuala Lumpur
Account No :	1419 4101 0002 039
Swift Code	MFBBMYKLXXX

To ensure that the full amount of your payment is received by us, please mark your bank transfer: 'PAY FULL AMOUNT' or 'Bank Charges Debit Account'.

NOTE: Premium payments made via Visa or MasterCard will incur a transaction fee of 2% - 4% of the total premium amount. All credit card fees paid in connection to Premiums to us are non-refundable.

N. DECLARATION AND AUTHORISATIONS

Read this section carefully before signing.

I/We understand and agree that the answers to the questions in section A, B, C, D, E, F, G, H, I, J, K, L and M above are true and complete. Where I have supplied full information from the Life Assured in this application and confirm that I have checked with him/her that the information is correct/accurate and reflect the current situation of the Life Assured provided that I have his/her consent to provide this information on his/her behalf.

I/We consent Archipelago Life Insurance Limited to contact my physician should further medical information be required to support my application. I also consent to Archipelago Life Insurance Limited dealing with my broker/financial advisor, if one is appointed, and that my medical information may be divulged to the appointed person only.

I/We understand and agree to be bound by the provisions of this proposal form

1. I/We hereby understand and agree that this proposal, together with Policy that will be issued to me/us once Archipelago Life Insurance Limited has approved my/our proposal, and any other related documents will govern the legal relationship between Archipelago Life Insurance Limited and me/us.
2. I/We confirm that all information provided in this proposal form and all other documents signed by me in connection with this proposal, whether in handwriting or not, are true and correct.
3. I/We are responsible for the accuracy and completeness of all answers or other information provided by me/us.
4. I/We understand that Archipelago Life Insurance Limited will accept instructions by facsimile, e-mail, or other electronic means from my/our Financial Advisor/Insurance Broker only if duly appointed and authorised in writing by me. Archipelago Life Insurance Limited will not be held liable for any losses that may result from unauthorised instructions given by my/our Financial Advisor/Insurance Broker.
5. I/We acknowledge that I/we am/are aware that this Plan is subjected to a fifteen (15) days free look period, starting from the date of receipt of Policy.

6. I/We agree that Archipelago Life Insurance Limited shall pay to my/our beneficiary(s) upon death in accordance with my beneficiary nominations in this proposal form, and I/We authorise Archipelago Life Insurance Limited to do so.
7. I/We consent Archipelago Life Insurance Limited to make enquiries of whatsoever nature for the purpose of verifying the information disclosed in this application.
8. I/We confirm that I/we am/are not (a) US Tax Resident person(s).
9. I/We confirm that my/our Attending Physician's Medical Report(s)/statement(s) can be released to Archipelago Life Insurance Limited for their underwriting purpose.
10. All information given here is correct and complete, and I/We authorize the Archipelago Life Insurance Limited to verify the same and obtain information from any financial institution, the Director General of Inland Revenue, credit information or credit references providers and any other sources.

Signature of Life Assured	
Name :	
Date :	
Signature of Proposer / Policyholder	
Name :	
Date :	
Company Stamp :	

O. INTERMEDIARY DETAILS AND DECLARATION

Intermediary Name :			
Intermediary Licence No :			
Intermediary Company Name :			
Company Licence No :			
Office No :		Mobile No. :	
Signature of Authorised Intermediary			
Name :			
Date :			

P. FOR OFFICE USE ONLY

Date Received :	DD / MM / YYYY
Accepting Officer :	
Data Entry :	☐ Yes ☐ No
Input Staff Name :	
Date :	DD / MM / YYYY
Underwriter :	
Date :	DD / MM / YYYY
Approved By :	
Date :	DD / MM / YYYY
Policy Number :	
Date of Issue :	DD / MM / YYYY
Date Despatched / Couriered :	DD / MM / YYYY

Q. CONTACT INFORMATION

Archipelago Life Insurance Limited

Co. No. LL09829 I Licence No. IS2013141

Registered Office Address:
Brumby Centre, Lot 42, Jalan Muhibbah,
87000 Labuan Federal Territories, Malaysia..

Co-located Office:
B-08-07, Gateway Corporate Suites, Gateway Kiaramas,
No.1 Jalan Desa Kiara, Mont Kiara,
50480 Kuala Lumpur, Malaysia

Telephone : +6 (03) 6201 0491
Fax : +6 (03) 6201 0481
Email : customerservice@archipelagolife.com
URL : www.archipelagolife.com