



Policy No.



**TOKIO MARINE**  
INSURANCE GROUP

**APPLICATION FORM - UPGRADING OF POLICY COVERAGE**

**IMPORTANT NOTICE:**

You should answer the questions asked by Us honestly, fully and accurately. Failure to give answers that are full and accurate may result in Your Policy being avoided, a claim not being paid or reduced, or the terms of the policy being changed. You are advised to take reasonable care not to make any misrepresentation when answering any questions asked by Us. In addition to answering the questions in the application form, You are also required to take reasonable care to tell Us any 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. You must inform Us if there is any change to the information previously disclosed by You in relation to your insurance contract before the contract is entered into or varied or renewed. If You do not understand Your duty as stated above or if You need any further explanation, You can contact Us or Our agent. If you are in any doubt about whether certain facts are material or relevant, these facts should be disclosed.

| PARTICULARS                    | LIFE ASSURED | POLICY OWNER<br>(IF DIFFERENT FROM LIFE ASSURED) |
|--------------------------------|--------------|--|
| Full Name as per NRIC/Passport |              |  |
| Handphone No.                  |              |  |
| Email Address                  |              |  |

**CONSENT FOR eCORRESPONDENCES**

By completing the email address above or by updating the email address, I hereby consent to receive all future correspondence relating to the Policy via electronic format and I authorize Tokio Marine Life Insurance Malaysia Bhd. to email such correspondences to me.

**PART 1: CHANGE OF POLICY INFORMATION**

| Policy Information  | Life Assured  | Policy Owner |
|---|---|--------------|
| 1. Date of Birth  |   |              |
| 2. Occupation<br>New Occupation:<br>Exact Duties:<br>Nature of Business:<br>Name of Employer: |   |              |
| 3. Annual Income (RM)   |   |              |
| 4. Source of Wealth (Policy Owner)  | <input type="checkbox"/> Employment <span style="float: right;"><input type="checkbox"/> Investment Income</span><br><input type="checkbox"/> Others, please specify _____  |              |
| 5. Source of Fund (Policy Owner)  | <input type="checkbox"/> Savings <span style="float: right;"><input type="checkbox"/> Withdrawal from Policy</span><br><input type="checkbox"/> Proceeds from Policy Surrender <span style="float: right;"><input type="checkbox"/> Proceeds from Policy Maturity</span><br><input type="checkbox"/> Others, please specify _____ |              |

|  |  |                               |
|--|--|-------------------------------|
|  |  | <p><i>For Office Use:</i></p> |
|--|--|-------------------------------|



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| PART 2: APPLICATION FOR RIDERS |  |   |  |   |
|--------------------------------|--|---|--|---|
| 1.                             | <input type="checkbox"/> Inclusion   | <input type="checkbox"/> Increase Sum Assured | <input type="checkbox"/> Upgrade Rider | <input type="checkbox"/> Increase Basic Premium |
| Type of Plan / Rider           | Amendment on   | New Sum Assured / Plan                        | New Basic Premium                      | New Term (If applicable)                        |
|                                | <input type="checkbox"/> Policy Owner<br><input type="checkbox"/> Life Assured |   |  |   |
| 2.                             | <input type="checkbox"/> Inclusion   | <input type="checkbox"/> Increase Sum Assured | <input type="checkbox"/> Upgrade Rider | <input type="checkbox"/> Increase Basic Premium |
| Type of Plan / Rider           | Amendment on   | New Sum Assured / Plan                        | New Basic Premium                      | New Term (If applicable)                        |
|                                | <input type="checkbox"/> Policy Owner<br><input type="checkbox"/> Life Assured |   |  |   |
| 3.                             | <input type="checkbox"/> Inclusion   | <input type="checkbox"/> Increase Sum Assured | <input type="checkbox"/> Upgrade Rider | <input type="checkbox"/> Increase Basic Premium |
| Type of Plan / Rider           | Amendment on   | New Sum Assured / Plan                        | New Basic Premium                      | New Term (If applicable)                        |
|                                | <input type="checkbox"/> Policy Owner<br><input type="checkbox"/> Life Assured |   |  |   |
| 4.                             | <input type="checkbox"/> Inclusion   | <input type="checkbox"/> Increase Sum Assured | <input type="checkbox"/> Upgrade Rider | <input type="checkbox"/> Increase Basic Premium |
| Type of Plan / Rider           | Amendment on   | New Sum Assured / Plan                        | New Basic Premium                      | New Term (If applicable)                        |
|                                | <input type="checkbox"/> Policy Owner<br><input type="checkbox"/> Life Assured |   |  |   |
| 5.                             | <input type="checkbox"/> Inclusion   | <input type="checkbox"/> Increase Sum Assured | <input type="checkbox"/> Upgrade Rider | <input type="checkbox"/> Increase Basic Premium |
| Type of Plan / Rider           | Amendment on   | New Sum Assured / Plan                        | New Basic Premium                      | New Term (If applicable)                        |
|                                | <input type="checkbox"/> Policy Owner<br><input type="checkbox"/> Life Assured |   |  |   |

| PART 3: HEALTH DECLARATION  |                          |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| Please answer ALL the questions below:  | Life Assured             |                          | Policy Owner             |                          |
| 1. What is your present height?   | _____ cm                 |                          | _____ cm                 |                          |
| 2. What is your present weight?   | _____ kg                 |                          | _____ kg                 |                          |
| Please answer ALL the questions below:  | Life Assured             |                          | Policy Owner             |                          |
|   | Yes                      | No                       | Yes                      | No                       |
| 3. Since the date of application for this policy, has there been any change in:   |                          |                          |                          |                          |
| a. Your nature of occupation, daily work duties, hobbies or sports (eg. private flying, hazardous sports, racing) or country of residence? If "YES", state the occupation/duties/ activities/country and date of each change. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Smoking of cigarettes, or the average number of cigarettes smoked; alcohol consumption, or the average quantity of alcohol consumed; Use of habit-forming drugs or narcotics? If "YES", please provide details.            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |



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| PART 3: HEALTH DECLARATION (CONTINUE)   |                          |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| Please answer ALL the questions below:  | Life Assured             |                          | Policy Owner             |                          |
|   | Yes                      | No                       | Yes                      | No                       |
| 4. Have you had or been told you had or been treated for diabetes, sugar in the urine, kidney disease, epilepsy, mental or nervous disorder, rheumatic fever, disorder of the heart, high blood pressure, chest pain, stroke, asthma, lung disease, blood disorder, ulcer, disorder of the digestive tract, liver, thyroid, venereal disease, Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS), any immunological disorder, Systemic Lupus Erythematosus (SLE), motor neurone disease, hereditary disease, disorder of the breast, disorder of any of the reproductive organs, complications at childbirth, cyst, tumors, cancers or any other disease, disorder, defect or injury? If "YES", please provide details. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. In the <b>PAST 5 YEARS</b> , have you had any diagnostic tests such as X-ray, biopsy, CT & MRI scan, electrocardiogram or blood study including blood test for AIDS and its related conditions? If "YES", please provide details.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. In the <b>PAST 3 MONTHS</b> , have you had any of the following symptoms for more than one week which is persistent and unexplained: fatigue, weight loss, diarrhoea, enlarged lymph nodes or unusual skin lesions? If "YES", please provide details.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have any intention to seek any medical advice, or to be hospitalized, or to undergo any surgical procedure or surgery or undergo any medical test (excluding yearly voluntary health screening) on the recommendation of a doctor? If "YES", please provide details.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Has any application or reinstatement of life or accident or health insurance ever been declined, postponed, rated or in any way modified; or is any application in this or other company pending? If "YES", please provide details.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. For <b>FEMALE</b> only   |                          |                          |                          |                          |
| a. Are your uterine functions at present normal?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Have you ever had any disorder of the breast or female organs or complications at child birth such as difficult labour or caesarean?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Are you pregnant? If yes, how many months?<br>_____ months   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Have you ever had a Pap Smear which you were advised to repeat within 6 months, or was found to be abnormal?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. If you have answered "YES" to any of the above questions, please indicate question No. and provide full details of the same:  |                          |                          |                          |                          |
|   |                          |                          |                          |                          |



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**PART 3: HEALTH DECLARATION (CONTINUE)**

| Please answer ALL the questions below:   | Life Assured   |  | Policy Owner  |    |
|--|--|--|---|----|
|  | Yes  | No   | Yes   | No |
| 11. For Life Assured (CHILD) only - Below 2 years only<br>a. Is your child in thorough good health now?<br>b. Has your child ever suffered from any illness, disease, impairment or injury, lame or deformed?<br>c. Has your child ever undergone any operation, treatment or medical tests?<br>d. Does your child suffer from any physical defects or mental disorder?<br>e. Was this child born abnormal or premature? If YES, please state number of weeks premature: _____ weeks<br>f. What was the birth weight? _____ kg | <input type="checkbox"/><br><br><input type="checkbox"/><br><br><input type="checkbox"/><br><br><input type="checkbox"/><br><br><input type="checkbox"/> | <input type="checkbox"/><br><br><input type="checkbox"/><br><br><input type="checkbox"/><br><br><input type="checkbox"/> | If answer to question 11(a) is 'NO' and 11(b) - 11(e) is 'YES', please provide full details here. |    |

**PART 4: DECLARATION**

- I) I/We understand that I/we have a pre-contractual duty of disclosure to take reasonable care not to make a misrepresentation when answering any questions asked by the Company.
- II) I am/We are at present in good health, sober and temperate habits, that the above answers are true, and that I/we have not concealed or withheld any facts which are required from me/us by the Company in order to grant me/us this insurance.
- III) I/We have read and understood the contents of this form including all warnings and notices and I/we have fully and accurately answered all the questions in this form and any other questions asked by the Company.
- IV) I/We understand that my/our answers and/or statements given in this application form, and any other relevant documents completed by me/us (including any amendments) in connection with my/our application and in any medical report shall be relied upon by the Company in deciding whether to accept my/our application and the rates and terms to be applied.
- V) I am/We are aware that I/WE must inform the Company in writing of any change to the answers given in this application form or any other relevant documents if the change occurred after the submission of this form but before the contract is entered into.
- VI) I/We understand that the said insurance shall not be effective until the premium in full has been actually received by the Company and the Endorsement has been issued to me/us during my/our or the life assured's life time.
- VII) I/We understand that no payment under or in connection with this application shall be binding on the Company unless an official receipt has been issued on the Company's printed form. If any premium be settled wholly or partly by cheque, note or other obligation, such obligation shall not be considered as payment but only as extension of the time for payment, and if not fully, paid when due, the Company shall not be liable if any claim occurs while such obligation remains unpaid after the grace period.
- VIII) I/We confirm and declare that in the course of this application, I/we have not made any statement and/or representation to the agent other than those written in this application form and I/we have not made any statement and/or representation which differs to the answers given in this application form. I/We confirm and declare that the agent has not made any statement or done any act that has influenced me/us in any manner or form to answer the questions in this application form incorrectly or untruthfully.
- IX) I/We hereby declare that the answers and declaration stated above are true and that the representations hereby given are intended to be relied upon by the Company in determining whether to grant me/us the insurance cover.
- X) If medical examination is required by the Company, I/we undertake to pay to the Company the cost of any medical fee (including X-ray, ECG etc.) in connection with this application should I/we fail to pay the premium on this application.
- XI) I/We hereby authorise any physician, hospital, clinic, insurance company or other organisation, institution or person that has any records or knowledge of me/our or my/our family member's health, to disclose to the Company or its representatives any and all such information. A copy of this authorisation shall be as effective and valid as the original.



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**PART 5: SINGLE PREMIUM TOP UP (For Upgrade Benefits purpose)  
(ONLY APPLICABLE FOR PAYMENT MODE UNDER QUARTERLY, SEMI-ANNUAL & ANNUAL)**

Please tick where applicable.

Single Premium Top-Up

| Type of Funds               | Percentage   | Top-Up Amount (RM) |
|-----------------------------|--------------|--------------------|
| TokioMarine-Enterprise Fund |              |                    |
| TokioMarine-Bond Fund       |              |                    |
| TokioMarine-Managed Fund    |              |                    |
| TokioMarine-Orient Fund     |              |                    |
| TokioMarine-Dana Ikhtiar    |              |                    |
| TokioMarine-Luxury Fund     |              |                    |
| Others:                     |              |                    |
| <b>TOTAL</b>                | <b>100 %</b> |                    |

| Check List  |
|---|
| <p><b>Single Premium Top-Up</b></p> <p><input type="checkbox"/> Minimum RM20<br/> <b>** only applicable for upgrading of policy coverage</b></p> <p><input type="checkbox"/> Investment allocation to follow existing Fund Allocation if it is not stated in the form</p> <p><input type="checkbox"/> One time deduction will be performed for Credit/Debit Card payment method</p> |

**PART 6: PRODUCT DISCLOSURE DECLARATION**

Please tick the box if you want to disclose the products

The product disclosure sheet(s) provides you with a summary of the main features of the Company's product(s)/rider(s) which you have selected to purchase along with a basic plan. Our representative will explain the summary outline of the product(s) to you. The information contained in this sheet is intended for illustration purpose and do not constitute a contract of insurance. Policy owners are advised to refer to the policy document for full details of the terms and conditions of the respective product(s)/ rider(s) including those outlined in the attachments(s) hereto.

**PART 7: AUTHORISATION**

I/We, the Policy Owner of the Policy, hereby authorize and request that the Policy be changed in accordance with the above particulars. I/We further agree that any alteration or variation shall not take effect until the request is approved by the Company.

Signed at \_\_\_\_\_ ( place ) on \_\_\_\_\_ ( date )

Signature of Life Assured \_\_\_\_\_

Signature of Policy Owner  
(Parent or Guardian to given consent if the Life Assured is of age 10 and above but below age 16)

\*Signature of Witness \_\_\_\_\_

Name : \_\_\_\_\_

Name : \_\_\_\_\_

Name : \_\_\_\_\_

NRIC No.: \_\_\_\_\_

NRIC No.: \_\_\_\_\_

NRIC No.: \_\_\_\_\_

Tel No. : \_\_\_\_\_

Tel. No. : \_\_\_\_\_

Tel. No. : \_\_\_\_\_



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**PART 7: AUTHORISATION (CONTINUE)**

I/We hereby consent for the Policy to be changed in accordance with the above particulars.

Signed at \_\_\_\_\_ ( place ) on \_\_\_\_\_ ( date )

\_\_\_\_\_  
Signature of Trustee/Parent/Guardian (where applicable)

Name :  
NRIC No.:  
Tel No. :

\_\_\_\_\_  
\*Signature of Witness

Name :  
NRIC No.:  
Tel. No. :

\_\_\_\_\_  
Signature of Trustee/Parent/Guardian (where applicable)

Name :  
NRIC No.:  
Tel No. :

\_\_\_\_\_  
\*Signature of Witness

Name :  
NRIC No.:  
Tel. No. :

**\*STATEMENT OF WITNESS :**

1. I hereby witness and certify that the signature(s) in this form was/were made before me and that to the best of my knowledge it is/ are the signature(s) of the Policy Owner/Life Assured/Trustee/Parent/Guardian under the Policy.
2. The Witness must be at least 18 years of age and of sound mind.

**Note: A copy of NRIC/Passport/Birth Certificate of the Policy Owner/Life Assured/Trustee/Parent/Guardian is submitted for verification by the Company.**

**PART 8: DATA PRIVACY**

I/We understand and agree that the information I/we supply will be collected, used and processed by the Company, its agents and its authorised parties (within or outside of Malaysia) for the purposes of processing this application and to facilitate the Company's function as an insurance company. I/We understand that I/We have a right to obtain access to and to request correction of my/our personal information held by the Company by contacting the Company's Customer Service Representatives.

Signed at \_\_\_\_\_ ( place ) on \_\_\_\_\_ ( date )

\_\_\_\_\_  
Signature of Policy Owner

Name:  
NRIC No.: