From:

To:
LONPAC INSURANCE BHD 199401021735 (307414-T)
6th Floor
Bangunan Public Bank
No. 6 Jalan Sultan Sulaiman
50000 Kuala Lumpur

POLICY RENEWAL / REPLACEMENT INSTRUCTION FORM
(PHM MediSavers 2015 / PHM MediSavers 2018 to MediSaversVIP Prime)

Insured Person : ____________________
New NRIC : ____________________
Plan Insured : ____________________
Expiry Date : ____________________

Agency A/C No. : ____________________
Renewal Policy No. : ____________________
Original Policy No. : ____________________
Premium Payment Frequency : ____________________

☐ Please renew my policy based on the existing terms and conditions and the applicable premium in force on the renewal date.

☐ Please replace my policy with MediSaversVIP Prime under the following plans:

- ☐ Plan 500 (Room & Board: RM500, Per Disability Limit: RM500,000, Overall Annual Limit: RM1,500,000) with Optional Top-Up Insurance (Room & Board: RM500, Per Disability Limit: RM1,000,000)
- ☐ Plan 500 (Room & Board: RM500, Per Disability Limit: RM500,000, Overall Annual Limit: RM1,500,000) without Optional Top-Up Insurance
- ☐ Plan 300 (Room & Board: RM300, Per Disability Limit: RM300,000, Overall Annual Limit: RM900,000) with Optional Top-Up Insurance (Room & Board: RM300, Per Disability Limit: RM1,000,000)
- ☐ Plan 300 (Room & Board: RM300, Per Disability Limit: RM300,000, Overall Annual Limit: RM900,000) without Optional Top-Up Insurance
- ☐ Plan 200 (Room & Board: RM200, Per Disability Limit: RM200,000, Overall Annual Limit: RM600,000) with Optional Top-Up Insurance (Room & Board: RM200, Per Disability Limit: RM1,000,000)
- ☐ Plan 200 (Room & Board: RM200, Per Disability Limit: RM200,000, Overall Annual Limit: RM600,000) without Optional Top-Up Insurance
- ☐ Plan 150 (Room & Board: RM150, Per Disability Limit: RM150,000, Overall Annual Limit: RM450,000) with Optional Top-Up Insurance (Room & Board: RM150, Per Disability Limit: RM1,000,000)
- ☐ Plan 150 (Room & Board: RM150, Per Disability Limit: RM150,000, Overall Annual Limit: RM450,000) without Optional Top-Up Insurance

I wish to opt for the following Deductible Amount under the MediSaversVIP Prime (please tick):

☐ RM3,000 ☐ RM6,000 ☐ RM10,000

I confirm that I have read the Product Disclosure Sheet and I agree to the following:

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

Important Note:
Item (a) to (d) does not apply to persons switching from Plan 2 under PHM MediSavers 2018 to Plan 500 under MediSaversVIP Prime. Switching from Plan 2 under PHM MediSavers 2018 to Plan 500 under MediSaversVIP Prime will require the submission of a fresh Proposal Form and Take-Over Policy Form for re-underwriting.

OPTIONAL TOP-UP INSURANCE

If my existing policy is without Optional Top-Up Insurance but the replacement policy is with Optional Top-Up Insurance, I declare that the answers to the following questions is deem to be added and shall form the basis of the replacement policy.

1. Has the person to be insured been hospitalised or surgically treated since the **Inception** of the medical insurance policy with Lonpac Insurance Bhd? ☐ Yes ☐ No
2. Has the person to be insured been diagnosed with a new disability or disabilities since the **Inception** of the medical insurance policy with Lonpac Insurance Bhd? ☐ Yes ☐ No

If the answer is 'Yes' to question 1 and 2, please provide details as below:

Question No.	Type of Disability	Date of Disability	Type of Treatment	Present State of Disability	Name & Address of Doctor and Hospital

If this space is insufficient, please write on a separate sheet of paper.

I understand that it is my duty to take reasonable care not to make a misrepresentation in answering the questions in this Policy Renewal/Replacement Instruction Form and I hereby declare that I have fully and accurately answered the questions above.

Signature of Policyholder ______________________________ *(Sign Here)* Date: ______________________________

(dd/mm/yyyy)