CONSENT FOR RELEASE OF INFORMATION

PROPOSAL NUMBER : ______________________________

PROPOSED INSURED : ______________________________

IDENTITY / NRIC NO OF PROPOSED INSURED : ______________________________

PROPOSED OWNER : ______________________________

IDENTITY / NRIC NO OF PROPOSED OWNER : ______________________________

CONSENT:

I, the undersigned, hereby authorize the below named individual agent of the physician, hospital, clinic records and / health disclosures to AXA AFFIN Life Insurance Berhad for the purpose of my insurance application. A copy of this authorization shall be as effective and valid as the original.

MEDICAL:

NAME OF ATTENDING DOCTOR : ______________________________

CLINIC / HOSPITAL NAME : ______________________________

: ______________________________

ADDRESS : ______________________________

: ______________________________

TELEPHONE NUMBER : ______________________________

AGENT :

NAME OF AGENT : ______________________________

NRIC OF AGENT : ______________________________

____

SIGNATURE OF PROPOSED INSURED/ OWNER

RELATIONSHIP TO PROPOSED INSURED : ______________________________

IDENTITY / NRIC NO : ______________________________

FULL NAME AS NRIC : ______________________________

DATE : ______________________________

NB VERSION 1.0 2018

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