

Non-Disclosure Consent Form

Critical Illness Application

Personal Details

Full Name: _____

Date of Birth: _____

ID / Passport Number: _____

Contact Number: _____

Address: _____

Consent Statement

I hereby acknowledge that I have been informed about the importance of full and honest disclosure in relation to my critical illness insurance application.

By signing this form, I provide my consent and confirm that I understand the following:

- I must disclose all material facts and medical information relevant to my application, even if not specifically requested.
- Failure to disclose relevant information or providing false information may result in denial of claim, policy cancellation, or other consequences as set by the insurer.
- I authorize the insurer to obtain information from relevant third parties, including medical practitioners and hospitals, if necessary.

Declaration

I declare that I have read and understood the above information. I voluntarily provide my consent and certify that the information I provide during my application is, to the best of my knowledge, complete and true.

Signature of Applicant: _____ Date: _____

Printed Name: _____ Witness (if required): _____

For office use only:

Application Ref: _____