

4. I understand that by providing false or misleading information, document or in which there is material omission to the PPA or PRS Provider, I am committing an offence under Section 139ZO of the Capital Market Services Act, and may be imprisoned not exceeding three years or to a fine not exceeding one million ringgit or to both.
5. I acknowledge and accept that the PRS Provider has absolute discretion to rely on this confirmation from me.

Signature of Member / Applicant*

Date (DD/MM/YY)

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For thumbprint verification
(Please refer to the Guide)

Signature of the medical practitioner
Name of the medical practitioner:
Date:

Medical institution Official Stamp

*Applicant refers to: Persons appointed by the courts or through power of attorney to manage the affairs of the member

H) FOR PRS PROVIDER USE ONLY

Fund Name	Withdrawal Units from Sub-Account B	Redemption Price (RM)	Withdrawal Amount (RM) from Sub-Account B
a)			
b)			
c)			
d)			
e)			

TOTAL Withdrawal Amount (RM)

For Office Use Only

CONSULTANT/STAFF CODE: _____	BRANCH NAME & CODE: _____
CONSULTANT/STAFF NAME: _____	SIGNATURE: _____
CONSULTANT/STAFF H/P NO.: _____	DATE: _____