



QUESTIONNAIRE

SECTION A: PARTICULARS OF LIFE ASSURED

Name

Identity Card / Passport No. Contract No.

SECTION B: MEDICAL QUESTIONS

1. What was the diagnosis made by the doctor?

2. When was this condition diagnosed?

3. Please describe your symptoms (eg coughing, wheezing, shortness of breath, chest tightness):

(a) Date of first occurrence of symptoms:

(b) Number of attacks per year:

(c) Date of last occurrence of symptoms:

(d) Severity and duration of each attack:

(e) Do your symptoms restrict your activities in any way?

Yes No

If 'Yes', please provide details

4. Are you aware of any specific factor which triggers your symptoms (eg exercise, stress, allergy)?

Yes No

If 'Yes', please provide details

5. Do you smoke cigarettes or any form of tobacco?

Yes No

If 'Yes', please provide details. Number of sticks per day Number of years

6. What treatment was or has been prescribed by your doctor?

Please tick accordingly and provide details:

Oral Medication

Name of Medication	Dosage	Frequency	Start Date of Medication	End Date of Medication (if applicable)

Inhaler

Name of inhaler	Dosage	Frequency	Date Of Last Treatment

Others, please provide details

Please specify date of last treatment (if applicable)

7. Have you undergone any investigations (eg x-ray, pulmonary function test)?

Yes No

If 'Yes', please provide details:

Type of Investigation / Test	Date	Results*	
		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal

* For abnormal results, please provide details

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8. Have you ever been admitted to hospital for this condition?

Yes No

If 'Yes', please provide details:

Name of Hospital	Date of Admission	Duration of Stay	Intensive Care Unit (ICU) or General Ward

9. Have you ever taken time off from work or school due to this condition?

Yes No

If 'Yes', please provide details:

Date	Duration of Time-off

10. Please provide the name and address of the doctor / clinic / hospital which you have consulted for this condition.

Name of Doctor / Clinic / Hospital	Address	Date of Last Consultation

Note: Please provide us with copies of all medical reports relating to this condition, if available.

SECTION C: DECLARATION

I/We agree to inform Singapore Life Ltd. if there is any change in my/our health status between the date of this Declaration and the date full insurance coverage is provided by Singapore Life Ltd. to me/us. I/We understand that the terms of accepting me/us as a risk for insurance coverage may vary according to such information received.

I/We agree that the above information shall form the basis of my/our application for insurance. I/We declare that the information given is true and complete and I/we have not withheld any material information that may influence the assessment of my/our application.

Name and Signature of Life Assured

Date (dd/mm/yyyy)

Name and Signature of Assured

Date (dd/mm/yyyy)