

QUESTIONNAIRE



SECTION A: PARTICULARS OF LIFE ASSURED

Name

Identity Card / Passport No. Contract No.

SECTION B: MEDICAL QUESTIONS

1. Please state the diagnosis made by the doctor.

2. When was this condition diagnosed?

3. Have you made a full recovery with no ongoing symptoms or treatment required?

Yes No

If 'Yes', how long has it been since your full recovery?

If 'No', how often do you experience symptoms and what are the symptoms?

4. 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)

Others, please provide details

Please specify date of last treatment (if applicable)

5. How frequent is your condition monitored or checked by your doctor?

6. Have you undergone any investigations or tests as a result of this condition?

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

7. Are there any further investigations, tests, treatment or surgery planned?

Yes No

If 'Yes', please provide details:

Date	Details

8. Do you have any complications as a result of your condition?

Yes No

If 'Yes', please provide details

9. Have you ever been admitted to hospital or had outpatient follow-up for this condition?

Yes No

If 'Yes', please provide details:

Name of Hospital	Date of Admission	Duration of Stay	Date of Last Follow-up

10. Have you taken time off work or school due to this condition?

Yes No

If 'Yes', please provide details:

Date	Duration of Time-off

11. 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)