



QUESTIONNAIRE

SECTION A: PARTICULARS OF LIFE ASSURED

Name

Identity Card / Passport No. Contract No.

SECTION B: MEDICAL QUESTIONS

1. When was this condition diagnosed?

2. Please state the diagnosis by the doctor:

- Insulin Dependent Diabetes Mellitus (IDDM) (Type 1)
- Non Insulin Dependent Diabetes Mellitus (NIDDM) (Type 2)
- Impaired Glucose Tolerance
- Impaired Fasting Glucose

3. 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)

Insulin

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

Diet control only

Others, please provide details

Please specify date of last treatment (if applicable)

4. Have you undergone any investigations?

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:

5. Please provide your last 3 blood glucose readings:

Date of Test	Blood Glucose Reading

6. Please provide your last 3 urine glucose results in terms of negative, +, ++, +++ or more:

Date of Test	Urine Glucose Reading

7. Please provide your last 3 HbA1c (glycosylated haemoglobin) test results:

Date of Test	HbA1c Reading

8. Have you ever had a diabetic (hyperglycaemic), insulin (hypoglycaemic) coma or been admitted to hospital due to any other diabetes related condition?

Yes No

If 'Yes', please provide details:

9. Have you ever had any of the following?

Please tick accordingly and provide details:

	Yes	No	If 'Yes', please provide details
Problems with your eyes/vision			
High Blood Pressure			
Albumin or protein in your urine			
Heart or circulatory disorder			
Numbness or tingling in your legs			

10. 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

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

Yes No

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

12. 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. ("Singlife") 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)