Musculoskeletal Disorder Supplementary (QA2)

* Q U E S T *

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. Have you undergone any investigations (eg X-ray, MRI)?

☐ Yes ☐ No

If **'Yes'**, please provide details:

Type of Investigation / Test	Date	Results*
		☐ Normal ☐ Abnormal
		☐ Normal ☐ Abnormal
		☐ Normal ☐ Abnormal
		☐ Normal ☐ Abnormal
		☐ Normal ☐ Abnormal

* For abnormal results, please provide details:

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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)

☐ **Physiotherapy**

Date of First Physiotherapy	Date of Last Physiotherapy

Are you still receiving ongoing physiotherapy?

☐ Yes ☐ No

If **'Yes'**, please provide the frequency of physiotherapy:

☐ **Others**, please provide details:

Type of Treatment	Frequency of Treatment	Date of First Treatment	Date of Last Treatment

Are you still receiving treatment?

☐ Yes ☐ No

If **'Yes'**, please provide type of treatment:

5. Please describe your symptoms

(a) How frequent do your symptoms occur (eg in the last 12 months)?

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(b) Which joint(s) or area(s) of the body are/were affected?

(c) Do you currently have any pain and/or related symptoms (eg numbness) of the affected part(s)?

☐ Yes ☐ No

If **'Yes'**, please provide details:

6. Have you had a surgery for this condition or is a surgery being considered?

☐ Yes ☐ No

If **'Yes'**, please provide details:

Date of Surgery	Nature of Surgery	Results

7. 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

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

☐ Yes ☐ No

If **'Yes'**, please provide details:

Date	Duration of Time-off

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9. 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)

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