



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*
		<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:

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)

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)?

(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

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)