Digestive Disorder Supplementary (QA9)

QUESTIONNAIRE

* Q U E S T *

Singlife with AVIVA

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

   (a) Date of first occurrence of symptoms

   (b) Number of attack(s) per year

   (c) Date of last occurrence of symptoms

4. Do you have any episode of bleeding?

   ☐ Yes ☐ No

   If **'Yes'**, how many times since onset and the dates of occurrence

5. Are your symptoms related to any particular factor (eg stress, alcohol, diet)?

   ☐ Yes ☐ No

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

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6. Have you undergone any investigations (eg gastroscopy, colonoscopy, barium meal)?

☐ 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:

7. Have you had a surgery for this condition or is a surgery being considered / planned?

☐ Yes ☐ No

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

Date of Surgery	Nature of Surgery	Results

8. 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)

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☐ **Regular Surveillance** (eg ultrasound / scan / scope)

Type of Test	Date of Last Test	Results	Date of Next Test

☐ **Others**, please provide details

Please specify date of last treatment (if applicable)

9. Have you taken time off 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)

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