



HEALTH DECLARATION FORM

For Official Use Only	
Group Policy No.:	
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Date: _____	

IMPORTANT NOTE: Pursuant to Section 25(5) of the Insurance Act (Cap.142), you are to disclose in this form, fully and faithfully, all the facts which you know or ought to know, otherwise, nothing may be payable under the Policy.

Name of Company: _____

Plan Type: _____

(A) EMPLOYEE'S PARTICULARS

Full Name of Proposed Insured in Block (as shown in NRIC - underline <u>surname</u>)				Nationality	Country of Residence	Height (cm)	Weight (kg)
NRIC / Passport No.	Date of Birth	Sex Male / Female #	Marital Status	Occupation - Exact Duties		Date of Employment	

(B) DEPENDANTS' INFORMATION (Please ignore this section if dependants are not covered)

Relationship	Name	Occupation	NRIC / Passport No.	Nationality	Country of Residence	Sex	Date of Birth DD / MM / YY	Height (cm)	Weight (kg)
Dependant 1									
Dependant 2									
Dependant 3									
Dependant 4									

(C) HEALTH QUESTIONS

(Note: Any alteration in this form must be signed.)

	Employee		Dependant 1		Dependant 2		Dependant 3		Dependant 4	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Have you ever had or been told to have or been treated for:										
a. epilepsy / fits, stroke, paralysis / weakness of limb, prolonged headache, nervous breakdown, depression or any other nervous / mental disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. cataract, ear infection / discharge or any other disorders of eye, ear, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. asthma, bronchitis, persistent cough, coughing with blood, pneumonia, tuberculosis, breathing complaints / discomfort or any other lung disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. raised cholesterol, high blood pressure, heart attack, mitral valve prolapse or other heart valve disorders, breathlessness, fast heart rate, chest pain, or any disease or disorders of the heart?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. diabetes mellitus, thyroid disorders or any endocrine disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. gastritis, stomach or duodenal ulcer, blood in stools, fistula, piles or any other stomach or bowel disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. jaundice, hepatitis B carrier or any form of hepatitis, liver or gallbladder disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. blood, protein or sugar in urine, kidney stones, infection or any other disorders of the kidney, bladder or genital organs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. cancer, tumour, cyst or growth of any kind?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. slipped disc, backache, gout, arthritis, pain or deformity or disorders of the muscles, spine, limbs or joints or severe injury?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. any sexually transmitted disease, e.g. syphilis, gonorrhoea, non-specific urethritis, herpes, HIV infection or AIDS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. endometriosis, fibroids, cysts, breast lumps, abnormal pap smear, irregular or painful menstruation or any other disorders of the female organs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. anaemia, haemophilia or any disorders of the blood?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. any other illnesses, congenital or hereditary disorders, any hospitalisation or physical injuries not listed above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you smoked in the last 12 months? If 'Yes', please state number of years and the number of sticks per day.										
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insured Person	No. of years		No. of sticks/day							
Employee										
Dependant 1										
Dependant 2										
Dependant 3										
Dependant 4										
3. Do you consume alcohol? If 'Yes', please state the type, quantity and frequency.										
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insured Person	Type	Quantity	Frequency (per week)							
Employee										
Dependant 1										
Dependant 2										
Dependant 3										
Dependant 4										

(cont'd...)

(...cont'd)

	Employee		Dependant 1		Dependant 2		Dependant 3		Dependant 4																					
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No																				
4. Do you have a regular doctor? If 'Yes', please state the name and address of your regular doctor and the date, reason and result of last consultation. _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
5. Have you consulted any doctor/specialist and had investigations done (X-Ray, ultrasound, Electrocardiogram, blood or urine tests) and/or prescriptions provided for any drugs or medications for any medical conditions other than common illness e.g. flu, common cough etc? If 'Yes', please state details such as reason, date and results of test done and the diagnosis. _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
6. Have you been recommended by a doctor to receive any medical treatment, undergo any medical tests, investigations (excluding voluntary health check-up) or any intention to consult any doctor for any reason, seek further treatment or alternative medicine? If 'Yes', please state details such as type, reason, date and results of test done and the diagnosis. _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
7. Do you engage in activities that will increase the likelihood of exposure to any immunity disorder such as AIDS or AIDS-related conditions or in the last 3 months had experienced the following symptoms for more than one week continuously: fatigue, weight loss, diarrhoea or unusual skin lesions? If 'Yes', please state details. _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
8. Have you ever been accepted at special terms or extra premiums for any application, renewal or reinstatement of life, health or any other insurance policy? If 'Yes', please provide details on date of application and reason for special terms. _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
9. Do you engage or have any intention of engaging in hazardous activity or occupation such as private flying, scuba diving, motor racing, mountaineering etc? If 'Yes', please state details such as locations, frequency, depth, etc. _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
10. Have any of your natural parents or siblings died or suffered from (a) heart disease, (b) high blood pressure, (c) stroke, (d) diabetes, (e) cancer, (f) kidney disease, (g) mental disorder, (h) muscular disorder, or any other hereditary disease? If 'Yes', please state relationship, condition, age of incidence of disease and age of death (if deceased).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
<table border="1"> <thead> <tr> <th>Relationship</th> <th>Condition/Cause of Death</th> <th>Age at Onset</th> <th>If Deceased, Age at Death</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>											Relationship	Condition/Cause of Death	Age at Onset	If Deceased, Age at Death																
Relationship	Condition/Cause of Death	Age at Onset	If Deceased, Age at Death																											

If any of the answers to Question 1 is YES, please PROVIDE COMPLETE INFORMATION and MEDICAL REPORT. If necessary, please attach a separate sheet.

Name	Sub-Qn. (Eg. a,b)	Details of Diagnosis / Treatment / Operation	Date		Name & Address of Doctor / Hospital
			From	To	

(D) DECLARATION

I declare that the information given above is true and complete. I agree that this application shall be the basis of the insurance coverage issued under the said Group Insurance Policy. I understand that the insurance coverage shall not become effective until it is accepted and confirmed in writing by Aviva Ltd.

I agree to inform Aviva Ltd if there is any change in the state of my and/or my dependants' health/activities between the date of this Health Declaration and the date full insurance coverage is provided by Aviva Ltd to me and/or my dependant(s). I understand that the terms of accepting me and/or my dependant(s) as a risk for insurance coverage may vary according to such information received.

I consent to Aviva Ltd seeking information from any doctor who has attended to me and/or my dependant(s) or from other insurance company to which I and/or my dependant(s) have at any time made a proposal for insurance and I authorise the giving of such information. I further authorise Aviva Ltd to give such information obtained or information contained herein for the purpose of obtaining insurance cover under the said Group Policy to the insurance intermediary / administrator of the said Group Insurance Policy.

Only applicable to Group Medical products for all voluntary and flexible benefits: I/We confirm that I/We have received a copy of Your Guide to Health Insurance and Product Summary and have read and understood the contents of these two documents.

Signature of Employee	Signature of Dependants aged 16 years and above			
	Signature of Dependant 1	Signature of Dependant 2	Signature of Dependant 3	Signature of Dependant 4
Date	Date	Date	Date	Date