



Hypertension – Supplementary Questionnaire

Q34

A. Particulars of Life to be Assured / Assured

|                    |   |       |
|--------------------|---|-------|
| Name               | : | _____ |
| NRIC/ Passport No. | : | _____ |
| Contract No.       | : | _____ |

B. Medical Questions

| No. | Questions   | Answers  |
|-----|---|--|
| 1.  | When were you first diagnosed with high blood pressure?   |  |
| 2.  | What was your blood pressure reading at that time?  |  |
| 3.  | Was your high blood pressure caused by anything specific?<br>(e.g. unknown, stress, pregnancy, overweight, other condition etc) |  |
| 4.  | What treatment did your doctor prescribe?   | <input type="checkbox"/> <b>Oral Medication:</b> <ul style="list-style-type: none"> <li>• Name of medication(s), dosage and frequency):</li> <li>• Date medication started:</li> <li>• Date medication discontinued if applicable:</li> </ul> <input type="checkbox"/> <b>Diet and exercise only</b><br><input type="checkbox"/> <b>Others</b> (Please provide details): |
| 5.  | Has your blood pressure returned to normal with no further symptoms or treatment required?                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>If Yes</b> , when did your blood pressure return to normal?   |
| 6.  | How frequently do you have your blood pressure monitored by your doctor?  |  |

|     |   |  |
|-----|---|--|
| 7.  | <p>When was your last consultation for blood pressure monitoring?</p> <p>What was your blood pressure reading at this consultation?</p>   | <p>Date of consultation:</p> <p>Reading:</p>   |
| 8.  | <p>Have you undergone any investigations or tests (such as ECG, urine tests, blood tests, vision tests), to check for complications or other conditions such as raised cholesterol, diabetes, kidney disorder or heart disease?</p> | <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>If Yes</b>, please provide the following:</p> <ul style="list-style-type: none"> <li>• Type of investigation or test:</li> <br/> <li>• Date of each investigation or test:</li> <br/> <li>• Result of each investigation or test</li> </ul> <p><input type="checkbox"/> Normal or negative</p> <p><input type="checkbox"/> Abnormal or positive (Please provide date and type of investigations or tests taken or conditions diagnosed):</p><br><p><input type="checkbox"/> Don't know (Please provide details of investigations or tests taken):</p> |
| 9a. | <p>Do you have any complications as a result of your high blood pressure?</p> <p>Kidney problems?</p>   | <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>If Yes</b>, please provide details:</p>   |
| 9b. | <p>Protein or albumin in your urine?</p>  | <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>If Yes</b>, please provide details:</p>   |
| 9c. | <p>Heart or circulatory problems?</p>   | <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>If Yes</b>, please provide details:</p>   |

|  |   |   |
|--|---|---|
| 9d.  | Vision problems?  | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>If Yes</b> , please provide details: |
| 9e.  | Others (Please provide details)?  | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>If Yes</b> , please provide details: |
| 10.  | Please provide the name and address of the doctor(s) / clinic / hospital you have consulted for this condition. |   |
| <b>Note: Please provide us with copies of all medical report relating to this condition, if available.</b> |   |   |

**C. Declaration**

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

I declare that the information given is true and complete and that I have not withheld any material information that may influence the assessment of my application.

Signature of Assured : \_\_\_\_\_ Date : \_\_\_\_\_

Signature of Life to be Assured : \_\_\_\_\_ Date : \_\_\_\_\_  
 (If other than the Assured)