



General Health – Supplementary Questionnaire

Q36

A. Particulars of Life to be Assured / Assured

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

B. Medical Questions

| No. | Questions | Answers |
|-----|--|---|
| 1. | Please state the final diagnosis made by the doctor. | |
| 2. | When was this condition first diagnosed? | |
| 3. | Have you made a full recovery with no ongoing symptoms or treatment required?? | <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , how long since your full recovery? If No , how often do you experience symptoms? |
| 4. | What treatment was or has been prescribed by your doctor? | <input type="checkbox"/> Oral Medication: <ul style="list-style-type: none"> • Name of medication(s), dosage and frequency): • Date medication started: • Date medication discontinued if applicable: <input type="checkbox"/> Others (Therapy, surgery etc - please provide details): <ul style="list-style-type: none"> • Date this treatment discontinued if applicable: |
| 5. | How frequently do you have your condition monitored or checked by your doctor? | |

| | | |
|--|---|---|
| 6. | Have you undergone any investigations or tests as a result of this condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , please provide the following: <ul style="list-style-type: none"> • Type of investigation or test: • Date of each investigation or test: • Result of each investigation or test <input type="checkbox"/> Normal or negative <input type="checkbox"/> Abnormal or positive (Please provide date and type of investigations or tests taken or conditions diagnosed): <input type="checkbox"/> Don't know (Please provide details of investigations or tests taken): |
| 7. | Are there any further investigations, tests, treatment or surgery planned? | <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , please provide details and dates: |
| 8. | Do you have any complications as a result of your condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , please provide details: |
| 9. | Please provide the name and address of the doctor(s) / clinic / hospital you have consulted for this condition: | |
| Note: Please provide us with copies of all medical report relating to this condition, if available. | | |

C. Declaration

| | |
|---|----------------------|
| <p>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.</p> <p>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.</p> | |
| Signature of Assured | : _____ Date : _____ |
| Signature of Life to be Assured (If other than the Assured) | : _____ Date : _____ |

