



Mental Health – Supplementary Questionnaire

Q40

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?	
3a.	When did you first experience symptoms?	
3b.	Please describe the nature of the symptoms	
3c.	Please state the duration of the symptoms	
3d.	Please state the no. of attacks since first occurrence?	
4.	What were the triggering factors or situation which triggers or exacerbates your symptoms or condition?	
5.	What treatment was or has been prescribed by your doctor?	<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>Others (Please provide details):</b> <ul style="list-style-type: none"> <li>• Date this treatment discontinued if applicable:</li> </ul>

6a.	Have you ever received psychiatric treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes</b> , please provide details:
6b.	Have you ever received psychotherapeutic therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes</b> , please provide details:
6c.	Have you ever received electroconvulsive therapy (ECT)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes</b> , please provide details:
7.	Have you ever had treatment as a hospital out-patient or seen a psychiatrist?	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes</b> , please provide when and where and what treatment you received:
8.	Have you ever been an in-patient at a hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes</b> , please provide period of hospitalisation, name of hospital and doctor/psychiatrist:
9.	Have you ever had any suicidal ideas, tendencies or actual suicide attempts?	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes</b> , please provide full details including the date(s) of occurrence and any follow-up treatment:
10.	Please provide details, dates and duration of any time off work/school due to this condition.	
11.	Please state date of last consultation.	
12.	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 (If other than the Assured) : \_\_\_\_\_ Date : \_\_\_\_\_