



Health Condition Amendment Form

Q46

A. Particulars of Life to be Assured / Assured

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

B. Amendments / Additional Information of new or existing medical condition

| No. | Questions | Answers |
|-----|---|---|
| 1. | Name of medical condition: | |
| 2. | Date of first symptoms or diagnosis: | <input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years <input type="checkbox"/> 5 years or more |
| 3. | Have you made a full recovery with no further treatment, ongoing symptoms or complications? | <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , how long since your full recovery: <input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years <input type="checkbox"/> 5 years or more If No , what treatment or medication did you take? |

| | | |
|----|---|--|
| 4. | <p>Have you undergone any investigations? (eg. x-ray, ultrasound, blood tests etc)</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, please provide the following:</p> <ul style="list-style-type: none"> • Type of investigation or test: • Date of each investigation or test: • Result of each investigation or test <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> <p><input type="checkbox"/> Don't know (Please provide details of investigations or tests taken):</p> <p><input type="checkbox"/> Others (please provide details):</p> <ul style="list-style-type: none"> • Date this treatment discontinued if applicable: |
| 5. | Please state date of last consultation. | |
| 9. | Please provide the name and address of the doctor(s) / clinic / hospital you have consulted for this condition: | |

| | | |
|---|---------------------|--|
| 10. | Other Declarations: | |
| <p>Note: Please provide us with copies of all medical report relating to this condition, if available.</p> | | |

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)