



Musculoskeletal Disorder – Supplementary Questionnaire

QA2

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 had any x-rays or other investigations?	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes</b> , please provide details including date(s) of investigations and results:
4.	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>Physiotherapy:</b> <ul style="list-style-type: none"> <li>• Date of start of physiotherapy:</li> <li>• Date of cessation of physiotherapy:</li> <li>• Frequency of physiotherapy:</li> </ul> <input type="checkbox"/> <b>Others</b> (Please provide details): <ul style="list-style-type: none"> <li>• Date this treatment discontinued if applicable:</li> </ul>

5a.	Regarding your symptoms: Please describe your symptoms.	
5b.	How frequently do symptoms occur? (e.g. How often in last 12 months)	
5c.	Is it restricted or limited to one area (please specify site) or generalised in nature?	
6.	Have you had an operation for this condition or is an operation being considered?	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes</b> , please provide full details including date(s) and type of operation:
7.	Please state date of last consultation.	
8.	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 : \_\_\_\_\_