



Chest Pain – Supplementary Questionnaire

QA3

**A. Particulars of Life to be Assured / Assured**

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

**B. Medical Questions**

No.	Questions	Answers
1a.	Please state the final diagnosis made by the doctor.	
1b.	When did you first experience chest pain?	
1c.	How frequently do you experience chest pain?	
1d.	When was the last attack and duration of attack?	
2.	Please describe the nature of the pain. (e.g. crushing, sharp, stabbing, dull ache, vague discomfort)	
3.	Please describe the factors precipitating the onset of symptoms/chest pain.	
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>Others (Please provide details):</b> <ul style="list-style-type: none"><li>• Date this treatment discontinued if applicable:</li></ul>

5.	Have you undergone any investigations or tests as a result of this condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes</b> , please provide the following: <ul style="list-style-type: none"> <li>• Type of investigation or test:</li>   <li>• Date of each investigation or test:</li>   <li>• Result of each investigation or test</li> </ul> <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):
6.	Are there any further investigations, tests, treatment or surgery planned?	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes</b> , please provide details and dates:
7.	Please state date of last consultation.	
8.	Have you been discharged from any future follow-ups reviews or investigations?	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes</b> , please provide details:
9.	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)