



Drug – Supplementary Questionnaire

QA8

A. Particulars of Life to be Assured / Assured

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

B. Questions

No.	Questions	Answers
1a.	Have you ever used any of the following drugs other than for treatment of a medical condition under proper medical supervision? Opiates (eg. Heroin, Opium, Morphine etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , please provide details:
1b.	Barbiturates (eg. Amytal, Tuinal, Seconal etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , please provide details:
1c.	Sedativesm (eg. Diazepam, Nitrazepam etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , please provide details:
1d.	Amphetamines (eg. Ecstasy, Ice etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , please provide details:
1e.	Cocaine	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , please provide details:
1f.	Hallucinogens (eg. LSD, DMT, Mescaline etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , please provide details:

1g.	Cannabis (eg. Marijuana, Hashish etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , please provide details:
1h.	Solvents (eg. Aerosols, Glue etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , please provide details:
1i.	Others	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , please provide details:
2.	Have you ever had any condition related to the use of drugs? (eg. Hepatitis, HIV infection, Mental illness etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , please provide the following: <ul style="list-style-type: none"> • Condition: • Date diagnosed: • When, where and what treatment you received:
3.	Have you ever sought medical treatment due to drug usage or detoxification?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , please provide period and type of treatment sought, name of hospital and doctor:

4.	Please provide any additional information which may have had bearing on any past or present use of drugs.	
5.	Are you now drug-free? I	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , how long since you are drug-free:
Note: Please provide us with copies of all medical report relating to this condition, if available.		

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 : _____