



Digestive Disorder – Supplementary Questionnaire

QA9

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.	Please describe your symptoms.	
3b.	When did your symptoms first occur?	
3c.	How frequently do symptoms occur, no. of attack per year?	
3d.	When was the last occurrence of symptoms?	
3e.	Do you have any episodes of bleeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes</b> , how many times since onset:
3f.	Are your symptoms related to any particular factors? (e.g. stress, alcohol, diet)	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes</b> , please provide details:
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? (e.g. gastroscopy, colonoscopy, barium meal etc)	<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.	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 details including date(s) and type of operation:
7.	Do you still have any recurrence of symptoms or complications arising from this condition since the last consultation or operation?	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes</b> , please provide details:
8.	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.	
<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)