



Ideal Income – Supplementary Questionnaire

QII

A. Particulars of Life to be Assured / Assured

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

B. Questions

No.	Questions	Answers
1.	Please state the name of your current job designation, current employer, nature of business and industry.	
2.	How long have you been engaged in your present occupation (length of service)? If less than 2 years, kindly state your previous occupation(s), nature of work, name(s) of previous employer(s) and the period with each employer.	
3.	Please describe the material duties involved in your occupation, starting with the task you do most. Where your job involves manual duties, you should include all significant tasks requiring physical mobility (eg. driving, lifting, cleaning etc.). <ul style="list-style-type: none"> ▪ If you have more than 3 material duties, please continue in the space provided. ▪ If the total percentages are less than 100, please list what other activities you are involved in. 	Duty 1 (_____)% Duty 2 (_____)% Duty 3 (_____)% Other Duties: (_____)% (_____)% _____ _____ _____ _____
4.	Are you holding more than one occupation?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide details:
5.	Please state your monthly gross salary.	Basic: \$ _____ per month Variable: \$ _____ per month

6.	How long would you continue to be paid from your employment in the event of disability?	
7.	Does your occupation require you to travel overseas?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , please provide the following: <ul style="list-style-type: none"> • Number of days or months per year: • Countries:
8.	Do you have any intention of changing your current occupation?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , please provide details:
9.	Are you now insured or proposing or contemplating to take up any sickness, disability or accident insurance in addition to this proposal?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , please provide the following: <input type="checkbox"/> Existing Insurance Policies: <ul style="list-style-type: none"> • Name of Insurance Company: • Type of Policy • Sum Assured / Monthly Benefit <input type="checkbox"/> Pending Insurance Applications: <ul style="list-style-type: none"> • Name of Insurance Company: • Type of Policy • Sum Assured / Monthly Benefit

10.	Have you ever made any claim(s) on health, accident or disability policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , please provide details of each claim and benefits received:
11.	Have you ever been incapacitated from work for more than four weeks or suffered from any serious illness or injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , please provide the following: <ul style="list-style-type: none"> • Nature of condition / injury: • Date / Duration: • Attending Physician: • Current Condition:

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)