

POLICY SERVICING HEALTH DECLARATION (For Health Products)



(Amendments and/or Additional Information on New or Existing Medical Conditions / Reinstatement / Reopen of New Business Application / Review of Underwriting Terms / Upgrade of Plan and/or Option)

Policy No. :			
Name of Life Assured / Insured Person :		NRIC / Passport No. :	
Name of Assured / Insured :		NRIC / Passport No. :	

Any disease or condition of health will not qualify for benefit unless it is fully disclosed to and accepted by us. You must, therefore, ensure that each question below is answered clearly and fully and that all material information, including any new disease or condition of health or any change in state of health, which arises or becomes known to you prior to the coverage effective date is given for consideration by us. Should you require more space for your answers please continue on a separate sheet and sign and date it.

If you are unsure whether any information is material or not, you are advised to disclose it.

SECTION A: HEALTH QUESTIONS

1.	What is your height?	metres
2.	What is your weight?	kg
3.	Have you smoked tobacco or cigarettes in the last 12 months ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Have you ever experience symptoms or received medical advice or had treatment for any of the following conditions (whether diagnosed or not)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(a)	Heart attack, chest pain or discomfort, irregular heart beat, heart valve disorder, heart murmur, palpitations or any other blood vessel or heart disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b)	High blood pressure or high cholesterol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c)	Cancer, tumour, cyst, lump or growth of any kind including cancer screening tests that were not normal?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d)	Diabetes, elevated or raised blood sugar, thyroid disorders or any other endocrine disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(e)	Asthma, bronchitis, pneumonia, tuberculosis, emphysema or any other breathing or lung disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(f)	Depression, anxiety, stress or any other mental or nervous disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(g)	Drug or alcohol addiction or abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(h)	Arthritis, gout or any other disorder, pain or injury to the muscles, bones, tendons, limbs, joints, spine (back or neck)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(i)	Stroke, epilepsy, fits, paralysis or weakness of limb, head injury or any other neurological disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(j)	Crohn's disease, ulcerative colitis, stomach or duodenal ulcers, or any other bowel, stomach or intestinal disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(k)	Hepatitis B or C, fatty liver, abnormal or elevated liver function, gallstones or any other liver or gallbladder disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(l)	AIDS, HIV or sexually transmitted disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(m)	Anaemia, thalassaemia, haemophilia or any other blood disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(n)	Kidney stones, kidney infection, urine abnormalities or any other kidney, bladder, prostate or gynaecological disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(o)	Eye, ear, nose or throat disease or disorder (excluding sight problems corrected by prescription lenses)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(p)	Any other illness, disorder, operation, physical disability or injury not mentioned above?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION A: HEALTH QUESTIONS *(continued)*

If you answered 'Yes' to any of the above Questions 4(a) to 4(p), please complete the following:

<p>Name of Condition</p> <p>Question () Condition:</p>	<p>Date of first symptoms or diagnosis</p> <p><input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years <input type="checkbox"/> 5 years or more</p>	<p>Have you made a full recovery with no further treatment, ongoing symptoms or complications?</p> <p><input type="checkbox"/> Yes How long since your full recovery?</p> <p><input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years <input type="checkbox"/> 5 years or more</p>	<p>Name and address of doctor who you consulted</p> <p>Name: Address:</p>
<p>Name of Condition</p> <p>Question () Condition:</p>	<p>Date of first symptoms or diagnosis</p> <p><input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years <input type="checkbox"/> 5 years or more</p>	<p>Have you made a full recovery with no further treatment, ongoing symptoms or complications?</p> <p><input type="checkbox"/> Yes How long since your full recovery?</p> <p><input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years <input type="checkbox"/> 5 years or more</p>	<p>Name and address of doctor who you consulted</p> <p>Name: Address:</p>
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<p>Name of Condition</p> <p>Question () Condition:</p>	<p>Date of first symptoms or diagnosis</p> <p><input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years <input type="checkbox"/> 5 years or more</p>	<p>Have you made a full recovery with no further treatment, ongoing symptoms or complications?</p> <p><input type="checkbox"/> Yes How long since your full recovery?</p> <p><input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years <input type="checkbox"/> 5 years or more</p>	<p>Name and address of doctor who you consulted</p> <p>Name: Address:</p>

SECTION A: HEALTH QUESTIONS (continued)

5.	<p>Other than conditions that you have already told us about, in the last 5 years have you had any abnormal medical test result from medical test(s) such as X-ray, ultrasound, imaging scan, biopsy, electrocardiogram (ECG), HIV test, blood or urine test, prostate check, pap smear or mammogram?</p> <p style="text-align:right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If 'Yes', please complete the following:</p>				
Name of medical test	Date of initial test	Have you had a follow-up test? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of follow-up test	Have you been prescribed treatment or been advised to have any further test? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name and address of doctor who you consulted
	<input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years	<p>If 'Yes', what was the result?</p> <input type="checkbox"/> normal <input type="checkbox"/> abnormal <input type="checkbox"/> don't know	<input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years	<p>If 'Yes', please provide details</p> <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	Name: Address:
Name of medical test	Date of initial test	Have you had a follow-up test? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of follow-up test	Have you been prescribed treatment or been advised to have any further test? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name and address of doctor who you consulted
	<input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years	<p>If 'Yes', what was the result?</p> <input type="checkbox"/> normal <input type="checkbox"/> abnormal <input type="checkbox"/> don't know	<input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years	<p>If 'Yes', please provide details</p> <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	Name: Address:
Name of medical test	Date of initial test	Have you had a follow-up test? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of follow-up test	Have you been prescribed treatment or been advised to have any further test? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name and address of doctor who you consulted
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6.	<p>Other than conditions that you have already told us about, are you currently experiencing symptoms or considering seeking medical advice or treatment for your health other than minor illnesses such as cold or flu?</p> <p style="text-align:right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If 'Yes', please complete the following:</p>				
What symptoms or condition?	Date of first symptoms	Date of any planned medical consultation			
	<input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 year or more				
What symptoms or condition?	Date of first symptoms	Date of any planned medical consultation			
	<input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 year or more				
What symptoms or condition?	Date of first symptoms	Date of any planned medical consultation			
	<input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 year or more				

