

Supplementary Questionnaire

ADDITIONAL QUESTIONNAIRES

Questionnaire on Hazardous Pursuits relating to question 4 of Section G (Refer to Global Protection Application Form)

	Life Assured	Assured / Joint Life Assured
1. What hazardous pursuit(s) are you involved in?		
2. How long have you participated in this activity?		
3. What qualifications do you hold?		
4. Do you belong to a club or an association?	<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please state name of the club/association: <input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please state name of the club/association: <input type="text"/>
5. Please indicate the number of events/trips/dives/climbs/jumps participated in the last 12 months.		
6. Please confirm the number of hours you engaged in this activity in the last 12 months.		
7. Please indicate the usual and maximum height/speed/depth in the space provided		
8. What equipment do you use?		
9. If using engine-propelled equipment, please confirm the engine size.		
10. Are you involved in any record attempts?	<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide full details: <input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide full details: <input type="text"/>
11. Which countries do you participate in this activity?		
12. Do you have any plans to become a professional?	<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide full details: <input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide full details: <input type="text"/>
13. Have you ever had an accident relating to this activity?	<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide full details: <input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide full details: <input type="text"/>
Answer the additional questions below only if you are involved in scuba diving:		
14. Do you ever dive unaccompanied or alone?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
15. Do you participate in cave or wreck-diving?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

**Questionnaire on High Blood Pressure
relating to question 8a of Section I (Refer to Global Protection Application Form)**

	Life Assured	Assured / Joint Life Assured
1. When were you first diagnosed?	Date: <input type="text"/>	Date: <input type="text"/>
2. What tests and investigations have you had?	What: <input type="text"/> When: <input type="text"/> Results: <input type="text"/>	What: <input type="text"/> When: <input type="text"/> Results: <input type="text"/>
3. What medication and/or treatment do you require?	Medication: <input type="text"/> Frequency: <input type="text"/> Treatment: <input type="text"/>	Medication: <input type="text"/> Frequency: <input type="text"/> Treatment: <input type="text"/>
4. How often do you have a follow-up review of your condition with your doctor?		
5. When was your blood pressure last taken and what was the reading?	Date: <input type="text"/> Reading: <input type="text"/>	Date: <input type="text"/> Reading: <input type="text"/>
6. Were the results of your last blood test confirmed to you as normal?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
7. Do you have any complications from this condition such as heart, kidney or blood vessel disorder?	<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide details: <input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide details: <input type="text"/>
8. Has your doctor confirmed to you that your condition is well controlled?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
9. Please provide the name and address of the doctor who treats you for this condition.	Name: <input type="text"/> Address: <input type="text"/>	Name: <input type="text"/> Address: <input type="text"/>

**Questionnaire on Raised Cholesterol
relating to question 8a of Section I (Refer to Global Protection Application Form)**

	Life Assured	Assured / Joint Life Assured
1. When were you first diagnosed?	Date: <input type="text"/>	Date: <input type="text"/>
2. What tests and investigations have you had?	What: <input type="text"/> When: <input type="text"/> Results: <input type="text"/>	What: <input type="text"/> When: <input type="text"/> Results: <input type="text"/>
3. What medication and/or treatment do you require?	Medication: <input type="text"/> Frequency: <input type="text"/> Treatment: <input type="text"/>	Medication: <input type="text"/> Frequency: <input type="text"/> Treatment: <input type="text"/>
4. How often do you have a follow-up review of your condition with your doctor?		
5. When was your blood cholesterol last tested and what was the reading?	Date: <input type="text"/> Reading: <input type="text"/>	Date: <input type="text"/> Reading: <input type="text"/>
6. Were the results of your last blood test confirmed to you as normal?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

(cont'd...)

(...cont'd Questionnaire on Raised Cholesterol)

	Life Assured	Assured / Joint Life Assured
7. Do you have any complications from this condition?	<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide full details: <input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide full details: <input type="text"/>
8. Has your doctor confirmed to you that your condition is well- controlled?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
9. Please provide the name and address of the doctor who treats you for this condition.	Name: <input type="text"/> Address: <input type="text"/>	Name: <input type="text"/> Address: <input type="text"/>

**Questionnaire on Tumour(s)
relating to question 8b of Section I (Refer to Global Protection Application Form)**

	Life Assured	Assured / Joint Life Assured
1. What is the name of your condition and where is it located?		
2. When were you first diagnosed?	Date: <input type="text"/>	Date: <input type="text"/>
3. Have you had a biopsy?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
4. Were the biopsy results confirmed to you as malignant or benign?		
5. Has your condition fully resolved?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
6. What treatment have you had for this and when did you have it?	Treatment: <input type="text"/> Date started: <input type="text"/> Date completed: <input type="text"/>	Treatment: <input type="text"/> Date started: <input type="text"/> Date completed: <input type="text"/>
7. Have you had any recurrence of this condition?	<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please indicate date of recurrence: <input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please indicate date of recurrence: <input type="text"/>
8. Are you under any ongoing follow-up with your doctor for this condition?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
9. When was your last consultation?	Date: <input type="text"/>	Date: <input type="text"/>
10. Please provide the name and address of the doctor who treats you for this condition.	Name: <input type="text"/> Address: <input type="text"/>	Name: <input type="text"/> Address: <input type="text"/>

**Questionnaire on Diabetes
relating to question 8c of Section I (Refer to Global Protection Application Form)**

	Life Assured	Assured / Joint Life Assured
1. What type of diabetes do you have?		
2. When were you first diagnosed?	Date: <input type="text"/>	Date: <input type="text"/>
3. What tests and investigations have you had?	What: <input type="text"/> When: <input type="text"/> Results: <input type="text"/>	What: <input type="text"/> When: <input type="text"/> Results: <input type="text"/>

(cont'd...)

(...cont'd Questionnaire on Diabetes)

	Life Assured	Assured / Joint Life Assured
4. What medication and/or treatment do you require?	Medication: <input type="text"/> Frequency: <input type="text"/> Treatment: <input type="text"/>	Medication: <input type="text"/> Frequency: <input type="text"/> Treatment: <input type="text"/>
5. How often do you have a follow-up review of your condition with your doctor?		
6. Do you have any complications from this condition such as a heart, kidney, eye or blood vessel disorder?	<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide full details: <input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide full details: <input type="text"/>
7. Has your doctor confirmed to you that your condition is well controlled?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
8. When was your last consultation?	Date: <input type="text"/>	Date: <input type="text"/>
9. Please provide the name and address of the doctor who treats you for this condition.	Name: <input type="text"/> Address: <input type="text"/>	Name: <input type="text"/> Address: <input type="text"/>

Questionnaire on Respiratory Conditions relating to question 8d of Section I (Refer to Global Protection Application Form)

	Life Assured	Assured / Joint Life Assured																
1. What respiratory condition do you have?																		
2. When did you first have symptoms?	Date: <input type="text"/>	Date: <input type="text"/>																
3. How often do you experience symptoms?																		
4. What medication and/or treatment do you require?	Medication: <input type="text"/> Frequency: <input type="text"/> Treatment: <input type="text"/>	Medication: <input type="text"/> Frequency: <input type="text"/> Treatment: <input type="text"/>																
5. In the last 2 years, have you required any time off work as a result of this condition?	<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide details: <table border="1"> <thead> <tr> <th>Date started</th> <th>Duration</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>	Date started	Duration							<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide details: <table border="1"> <thead> <tr> <th>Date started</th> <th>Duration</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>	Date started	Duration						
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Date started	Duration																	
6. In the last 2 years, have you required emergency treatment or hospitalisation for this condition?	<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide details: <table border="1"> <thead> <tr> <th>Date started</th> <th>Duration</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>	Date started	Duration							<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide details: <table border="1"> <thead> <tr> <th>Date started</th> <th>Duration</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>	Date started	Duration						
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7. In the last 2 years, have you required oral steroids to treat this condition?	<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide details: <table border="1"> <thead> <tr> <th>Date started</th> <th>Duration of treatment</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>	Date started	Duration of treatment							<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide details: <table border="1"> <thead> <tr> <th>Date started</th> <th>Duration of treatment</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>	Date started	Duration of treatment						
Date started	Duration of treatment																	
Date started	Duration of treatment																	

(cont'd...)

(...cont'd Questionnaire on Respiratory Conditions)

	Life Assured	Assured / Joint Life Assured
8. Has your doctor confirmed to you that your condition is well controlled?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
9. When was your last consultation?	Date: <input type="text"/>	Date: <input type="text"/>
10. Please provide the name and address of the doctor who treats you for this condition.	Name: <input type="text"/> Address: <input type="text"/>	Name: <input type="text"/> Address: <input type="text"/>

**Questionnaire on Mental Health
relating to question 8e of Section I (Refer to Global Protection Application Form)**

	Life Assured	Assured / Joint Life Assured																
1. What condition do you have?	<input type="text"/>	<input type="text"/>																
2. When were you first diagnosed?	Date: <input type="text"/>	Date: <input type="text"/>																
3. Have you had more than one episode?	<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide details: <table border="1"> <thead> <tr> <th>Date started</th> <th>Duration</th> </tr> </thead> <tbody> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> </tbody> </table>	Date started	Duration	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide details: <table border="1"> <thead> <tr> <th>Date started</th> <th>Duration</th> </tr> </thead> <tbody> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> </tbody> </table>	Date started	Duration	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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4. What medication and/or treatment do you require?	Medication: <input type="text"/> Frequency: <input type="text"/> Treatment: <input type="text"/>	Medication: <input type="text"/> Frequency: <input type="text"/> Treatment: <input type="text"/>																
5. How often do you have a follow-up review of your condition with your doctor?	<input type="text"/>	<input type="text"/>																
6. Have you required psychiatric care or hospitalisation?	<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide details: <table border="1"> <thead> <tr> <th>Date started</th> <th>Duration</th> </tr> </thead> <tbody> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> </tbody> </table>	Date started	Duration	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide details: <table border="1"> <thead> <tr> <th>Date started</th> <th>Duration</th> </tr> </thead> <tbody> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> </tbody> </table>	Date started	Duration	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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7. Have you ever attempted suicide?	<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide date(s) of attempt(s): <input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide date(s) of attempt(s): <input type="text"/>																
8. Does your doctor consider your condition to be well controlled?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No																
9. When was your last consultation?	Date: <input type="text"/>	Date: <input type="text"/>																
10. Please provide the name and address of the doctor who treats you for this condition.	Name: <input type="text"/> Address: <input type="text"/>	Name: <input type="text"/> Address: <input type="text"/>																

**Questionnaire on Musculoskeletal conditions
relating to question 8f of Section I (Refer to Global Protection Application Form)**

	Life Assured	Assured / Joint Life Assured																
1. What part of your body is affected (please also indicate 'left' or 'right' if applicable)?																		
2. What condition do you have?																		
3. When did you first have symptoms?																		
4. Have you had more than one episode or event?	<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide details: <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;">Date started</th> <th style="width: 50%;">Duration</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>	Date started	Duration							<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide details: <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;">Date started</th> <th style="width: 50%;">Duration</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>	Date started	Duration						
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Date started	Duration																	
5. What was the cause of this condition?																		
6. How often do you experience symptoms?																		
7. What medication and/or treatment do you require?	Medication: <input style="width: 100%;" type="text"/> Frequency: <input style="width: 100%;" type="text"/> Treatment: <input style="width: 100%;" type="text"/>	Medication: <input style="width: 100%;" type="text"/> Frequency: <input style="width: 100%;" type="text"/> Treatment: <input style="width: 100%;" type="text"/>																
8. Is there any surgery or other investigations planned?	<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide full details: <div style="border: 1px solid black; height: 40px; width: 100%; margin-top: 5px;"></div>	<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide full details: <div style="border: 1px solid black; height: 40px; width: 100%; margin-top: 5px;"></div>																
9. Is there any restriction in your ability to carry out your daily activities?	<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide full details: <div style="border: 1px solid black; height: 40px; width: 100%; margin-top: 5px;"></div>	<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide full details: <div style="border: 1px solid black; height: 40px; width: 100%; margin-top: 5px;"></div>																
10. Please provide the name and address of the doctor who treats you for this condition.	Name: <input style="width: 100%;" type="text"/> Address: <input style="width: 100%;" type="text"/>	Name: <input style="width: 100%;" type="text"/> Address: <input style="width: 100%;" type="text"/>																

**Questionnaire on other conditions
relating to Question 8 Section I (Refer to Global Protection Application Form)**

Health Condition 1	Life Assured	Assured / Joint Life Assured																
1. What condition do you have?																		
2. When were you first diagnosed?	Date: <input type="text"/>	Date: <input type="text"/>																
3. How often do you experience symptoms?																		
4. What medication and/or treatment do you require?	Medication: <input type="text"/> Frequency: <input type="text"/> Treatment: <input type="text"/>	Medication: <input type="text"/> Frequency: <input type="text"/> Treatment: <input type="text"/>																
5. Have you been hospitalised or had more than 2 weeks off work as a result?	<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide details: <table border="1"> <thead> <tr> <th>Date started</th> <th>Duration</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>	Date started	Duration							<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide details: <table border="1"> <thead> <tr> <th>Date started</th> <th>Duration</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>	Date started	Duration						
Date started	Duration																	
Date started	Duration																	
6. Does your doctor consider your condition to be well controlled?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No																
7. When was your last consultation?	Date: <input type="text"/>	Date: <input type="text"/>																
8. Have you fully recovered from the condition?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No																
9. Please provide the name and address of the doctor who treats you for this condition.	Name: <input type="text"/> Address: <input type="text"/>	Name: <input type="text"/> Address: <input type="text"/>																

Health Condition 2	Life Assured	Assured / Joint Life Assured																
1. What condition do you have?																		
2. When were you first diagnosed?	Date: <input type="text"/>	Date: <input type="text"/>																
3. How often do you experience symptoms?																		
4. What medication and/or treatment do you require?	Medication: <input type="text"/> Frequency: <input type="text"/> Treatment: <input type="text"/>	Medication: <input type="text"/> Frequency: <input type="text"/> Treatment: <input type="text"/>																
5. Have you been hospitalised or had more than 2 weeks off work as a result?	<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide details: <table border="1"> <thead> <tr> <th>Date started</th> <th>Duration</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>	Date started	Duration							<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide details: <table border="1"> <thead> <tr> <th>Date started</th> <th>Duration</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>	Date started	Duration						
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Date started	Duration																	
6. Does your doctor consider your condition to be well controlled?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No																
7. When was your last consultation?	Date: <input type="text"/>	Date: <input type="text"/>																
8. Have you fully recovered from the condition?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No																
9. Please provide the name and address of the doctor who treats you for this condition.	Name: <input type="text"/> Address: <input type="text"/>	Name: <input type="text"/> Address: <input type="text"/>																

Health Condition 3	Life Assured	Assured / Joint Life Assured																
1. What condition do you have?																		
2. When were you first diagnosed?	Date: <input type="text"/>	Date: <input type="text"/>																
3. How often do you experience symptoms?																		
4. What medication and/or treatment do you require?	Medication: <input type="text"/> Frequency: <input type="text"/> Treatment: <input type="text"/>	Medication: <input type="text"/> Frequency: <input type="text"/> Treatment: <input type="text"/>																
5. Have you been hospitalised or had more than 2 weeks off work as a result?	<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide details: <table border="1"> <thead> <tr> <th>Date started</th> <th>Duration</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>	Date started	Duration							<input type="radio"/> Yes <input type="radio"/> No If 'Yes', please provide details: <table border="1"> <thead> <tr> <th>Date started</th> <th>Duration</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>	Date started	Duration						
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Date started	Duration																	
6. Does your doctor consider your condition to be well controlled?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No																
7. When was your last consultation?	Date: <input type="text"/>	Date: <input type="text"/>																
8. Have you fully recovered from the condition?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No																
9. Please provide the name and address of the doctor who treats you for this condition.	Name: <input type="text"/> Address: <input type="text"/>	Name: <input type="text"/> Address: <input type="text"/>																

Signature of Life Assured

 / /

Date (dd/mm/yy)

Signature of Assured / Company Stamp#
(as applicable) (if the Assured is different from the Life Assured) / Joint Life Assured

#The signatory warrants that he or she has the authority to sign for and on behalf of _____ (Name of Company) and to bind the Company by his or her signature.

Name & Designation of Signatory (if applicable)

 / /

Date (dd/mm/yy)

Signature of Witness

Name of Witness

Identity Card/Passport No.

 / /

Date (dd/mm/yy)

I have sighted the customer(s)' original copy of Identity Card/Passport and taken a copy.

Signature of Adviser

Name of Adviser

If there is insufficient space to any of the above, please continue on the space provided here. Otherwise, please continue on to another sheet of paper.



