



HEALTH DECLARATION FORM

For Official Use Only Group Policy No.:							
<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> </tr> </table>							
Date: _____							

IMPORTANT NOTE: Pursuant to Section 25(5) of the Insurance Act (Cap. 142), you are to disclose in this form, fully and faithfully, all the facts which you know or ought to know, otherwise, nothing may be payable under the Policy.

Name of Company: _____

Plan Type: _____

(A) EMPLOYEE'S PARTICULARS

Full Name of Proposed Insured in Block (as shown in NRIC - underline surname)				Nationality	Race Asian <input type="checkbox"/> Others <input type="checkbox"/>	Country of Residence	Height (cm)	Weight (kg)
NRIC / Passport No.	Date of Birth	Gender Male / Female #	Marital Status	Occupation - Exact Duties			Date of Employment	

(B) DEPENDANT'S INFORMATION (Please ignore this section if dependants are not covered)

Relationship	Name	Occupation	NRIC / Passport No.	Nationality	Race	Country of Residence	Date of Birth DD / MM / YY	Height (cm)	Weight (kg)
Dependant 1					Asian <input type="checkbox"/> Others <input type="checkbox"/>				
Dependant 2					Asian <input type="checkbox"/> Others <input type="checkbox"/>				
Dependant 3					Asian <input type="checkbox"/> Others <input type="checkbox"/>				
Dependant 4					Asian <input type="checkbox"/> Others <input type="checkbox"/>				

(C) HEALTH QUESTIONS

(Note: Any alteration in this form must be signed.)

	Employee		Dependant 1		Dependant 2		Dependant 3		Dependant 4	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Have you ever had or been told to have or been treated for:										
a. epilepsy / fits, stroke, paralysis / weakness of limb, prolonged headache, nervous breakdown, depression or any other nervous / mental disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. ear discharge, nose bleeds, double vision, impaired sight, hearing, or speech or any other disorders of ear, eye, nose and throat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. asthma, bronchitis, persistent cough, coughing with blood, pneumonia, tuberculosis, breathing complaints / discomfort or any other lung disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. raised cholesterol, high blood pressure, heart attack, mitral valve prolapse or other heart valve disorders, breathlessness, irregular heart rate, chest pain, or any disease or disorders of the heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. diabetes mellitus, thyroid disorders or any endocrine disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. gastritis, stomach or duodenal ulcer, blood in stools, fistula, piles or any other stomach or bowel disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. jaundice, hepatitis B carrier or any form of hepatitis, liver or gallbladder disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. blood, protein or sugar in urine, kidney stones, infection or any other disorders of the kidney, bladder or genital organs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. cancer, tumour, cyst or growth of any kind?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. slipped disc, gout, arthritis, pain or deformity or disorders of the muscles, spine, limbs or joints or severe injury?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. any sexually transmitted disease or have received any medical advice or counselling for AIDS related conditions (including HIV positive)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. endometriosis, fibroids, breast and/or ovarian cysts/lumps/tumours, abnormal pap smear, irregular or painful menstruation or any other gynaecological disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. anaemia, haemophilia or any disorders of the blood or any other congenital or hereditary disorders not listed above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Other than the conditions listed above, have you had any other health condition which led to:										
- more than 10 consecutive days off work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- more than 5 consecutive days of hospital admission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- follow up consultations or treatment lasting more than a month	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you smoked cigarettes in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If 'Yes', please state number of sticks smoked per day and the number of years.										
	No. of sticks/day		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	No. of years		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3. Do you consume alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If 'Yes', please state the type, quantity and frequency.										
	Type		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Quantity		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Frequency (per week)		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

(cont'd...)

	Employee		Dependant 1		Dependant 2		Dependant 3		Dependant 4																								
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No																							
4. Have you ever been treated for drug or alcohol addiction?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																							
5. Have you had - any biopsy, CT scans, or - any abnormal or pending investigations, scans, blood or urine tests? If 'Yes', please provide below details such as reason, date and results of test done and the diagnosis: Reason: _____ Date: _____ Type of test(s): _____ Result: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																							
6. Have you ever been accepted at special terms or rates, deferred or declined for any application, renewal, or reinstatement of life, accident, health disability or other insurance policy? If 'Yes', please provide details on date of application and reason for special terms. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																							
7. Do you engage or have any intention of engaging in hazardous activity or occupation such as private flying, scuba diving, motor racing, mountaineering etc? If 'Yes', please state details such as locations, frequency, depth, etc. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																							
8. Have any of your natural parents or siblings died or suffered from (a) heart disease, (b) high blood pressure, (c) stroke, (d) diabetes, (e) cancer, (f) kidney disease, (g) mental disorder, (h) muscular disorder, or any other hereditary disease? If 'Yes', please state relationship, condition, age at onset of condition and age at death (if deceased).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																							
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If any of the answers to Question 1 is YES, please PROVIDE COMPLETE INFORMATION and MEDICAL REPORT. If necessary, please attach a separate sheet.

Name	Sub-Qn. (Eg. a,b)	Medical Condition	Date of Diagnosis	Treatment		Name & Address of Doctor / Hospital	Current medical status (eg. fully recovered, follow up treatment/investigation required?)
				Date	Duration		

(D) PERSONAL DATA CONSENT(S)

On behalf of myself and my dependants, I/we consent to Aviva (and Aviva related group of companies) collecting, using and/or disclosing my/our personal data to issue and administer my existing and/or new policies or insurance coverage(s) with Aviva.

On behalf of myself and my dependents, I/we also consent to Aviva (and Aviva related group of companies) transferring my/our personal data to Aviva related group of companies and/or third party service providers, reinsurers, suppliers or intermediaries, whether located in Singapore or elsewhere, for the above purposes.

For full details of the purposes of collection, use and disclosure of your personal data, please visit <http://www.aviva.com.sg/pdpa.html>

(E) DECLARATION

I/We declare that all the information on this Application Form is true and complete to the best of my knowledge and understands that any misrepresentation or concealment of facts shall render the policy to be issued null and void. I agree that this application shall be the basis of the insurance coverage issued under the said Group Insurance Policy. I understand that the insurance coverage shall not become effective until it is accepted and confirmed in writing by Aviva Ltd.

I agree to inform Aviva Ltd if there is any change in the state of my and/or my dependants' health/activities between the date of this Health Declaration and the date full insurance coverage is provided by Aviva Ltd to me and/or my dependant(s). I understand that the terms of accepting me and/or my dependant(s) as a risk for insurance coverage may vary according to such information received.

I consent to Aviva Ltd seeking information from any doctor who has attended to me and/or my dependant(s) or from other insurance company to which I and/or my dependant(s) have at any time made a proposal for insurance and I authorise the giving of such information. I further authorise Aviva Ltd to give you such information obtained or information contained herein for the purpose of obtaining insurance cover under the said Group Policy to the insurance intermediary / administrator of the said Group Insurance Policy.

I/We am/are aware that the product I/We am/are applying for is authorised for sale in Singapore and I/we acknowledge that the laws and regulations applicable to my /our nationality and country of residence allows my/our purchase of this product. I/We understand that no liability can be accepted by Aviva for any legal consequences under the laws of any other country or any tax implications that may arise in connection with my/our purchase of this product.

Only applicable to Group Medical products for all voluntary and flexible benefits: I/We confirm that I/we have received a copy of Your Guide to Health Insurance and Product Summary and have read and understood the contents of these two documents.

Signature of Employee	Signature of Dependants aged 16 years and above			
	Signature of Dependant 1	Signature of Dependant 2	Signature of Dependant 3	Signature of Dependant 4
Date <input type="text" value="D, D"/> <input type="text" value="M, M"/> 20 <input type="text" value="Y, Y"/>	Date <input type="text" value="D, D"/> <input type="text" value="M, M"/> 20 <input type="text" value="Y, Y"/>	Date <input type="text" value="D, D"/> <input type="text" value="M, M"/> 20 <input type="text" value="Y, Y"/>	Date <input type="text" value="D, D"/> <input type="text" value="M, M"/> 20 <input type="text" value="Y, Y"/>	Date <input type="text" value="D, D"/> <input type="text" value="M, M"/> 20 <input type="text" value="Y, Y"/>

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