

	If "Yes", please give details such as date of occurrence, investigation / treatment provided and name / address doctor.			
	Yes	No		
e. diabetes mellitus, thyroid disorder or any endocrine disease?	<input type="checkbox"/>	<input type="checkbox"/>		
f. gastritis, stomach or duodenal ulcer, blood in stools, fistula, piles or any other stomach or bowel disorder?	<input type="checkbox"/>	<input type="checkbox"/>		
g. jaundice, hepatitis B carrier or any form of hepatitis, liver or gallbladder disorder?	<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"/>		
i. cancer, tumour, cyst or growth of any kind?	<input type="checkbox"/>	<input type="checkbox"/>		
j. slipped disc, backache, gout, arthritis, pain or deformity or disorders of the muscles, spines, limbs or joints or severe injury?	<input type="checkbox"/>	<input type="checkbox"/>		
k. any sexually transmitted disease, eg syphilis, gonorrhoea, non-specific urethritis, herpes, HIV infection or AIDS?	<input type="checkbox"/>	<input type="checkbox"/>		
l. endometriosis, fibroids, cysts, breast lumps, abnormal pap smear, irregular or painful menstruation or any other disorders of the female organs?	<input type="checkbox"/>	<input type="checkbox"/>		
m. anaemia, haemophilia or any disorders of the blood?	<input type="checkbox"/>	<input type="checkbox"/>		
n. any other illnesses, congenital or hereditary disorders, any hospitalisation or physical	<input type="checkbox"/>	<input type="checkbox"/>		
5. Have you ever received any blood transfusion or ever been refused as a blood donor?	<input type="checkbox"/>	<input type="checkbox"/>		
6. Have you smoked in the past 12 months? If "Yes", please state numbers of years and the number of sticks per day.	<input type="checkbox"/>	<input type="checkbox"/>		
7. Do you consume alcohol? If "Yes", please state the quantity, type and frequency.	<input type="checkbox"/>	<input type="checkbox"/>		
8. Do you engage in hazardous activity such as aviation (other than as a private paying passenger), scuba/skin diving, motor racing, mountaineering, etc?	<input type="checkbox"/>	<input type="checkbox"/>		
9. Do you engage in activities that will increase exposure to AIDS or AIDS related conditions?	<input type="checkbox"/>	<input type="checkbox"/>		
10. 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?	<input type="checkbox"/>	<input type="checkbox"/>		
	Relationship	Condition/cause of Death	Age at offset	If Deceased, Age at Death

C. PERSONAL DATA

On Behalf of myself and dependents, 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>

D.

I declare that the answers were given by me in reply to the questions put to me and to the best of my knowledge and belief, the information furnished herein are true and complete and I agree that they are in continuation of and form part of my proposal and that failure to disclose any material known fact to me may invalidate the Policy. 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/Medical Examination 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 authorise any medical source, insurance office or organisation to release to Aviva Ltd and similarly Aviva Ltd to release to any of the prior mentioned organisations, relevant information concerning me at any time, irrespective of whether the proposal is accepted by Aviva Ltd. A photographic copy of this authorization shall be as valid as the original.

Only applicable to Group Medical products (including Livingcare & Disability Income) 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 Examinee

Signature of Medical Examiner

Date 20

Date 20

MEDICAL EXAMINATION FORM (PART II) - MEDICAL EXAMINER'S CONFIDENTIAL

This examination should be in private, without the presence of a third party except as chaperon or interpreter. The medical examiner is requested to send this report in a sealed envelope as it is strictly confidential between the Company and the examiner. Please note that we may be obliged to disclose results of the medical examination to the examinee at his request.

A. PLEASE ANSWER THE FOLLOWING QUESTIONS (To be answered by the Medical Examiner)

	Yes	No	Please give full details of any abnormality												
1. Are you personally acquainted with the examinee? If so, in what capacity and please provide details of any consultations?	<input type="checkbox"/>	<input type="checkbox"/>													
2. CNS, SKELETAL SYSTEM a) Are there any diseases of the central or peripheral nervous system? b) Are the tendon reflexes abnormal ? c) Any paralysis or tremors? d) Any bones or joints deformity, amputation?	<input type="checkbox"/>	<input type="checkbox"/>													
3. CHEST a) Are the shape, capacity & expansion of the chest unsatisfactory ? b) Are the breath sounds abnormal ? If not, please describe the adventitious sounds heard.	<input type="checkbox"/>	<input type="checkbox"/>													
4. HEART a) Is the Apex beat abnormal ? b) Are there any signs of hypertrophy or dilatation? c) Are there any abnormalities in the heart sounds? d) Are there any murmurs? If Yes, please indicated the grade of murmurs. e) Blood pressure - (if SBP>140, or DBP>90 (5th phase), please take 2 further readings with interval of 5 minutes. If the examinee is hypertensive, please state, if known, the readings with relevant dates.	<input type="checkbox"/>	<input type="checkbox"/>	PULSE RATE beats/minutes _____ *Regular / Irregular												
			<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">BLOOD PRESSURE</th> <th style="width: 10%;">1</th> <th style="width: 10%;">2</th> <th style="width: 10%;">3</th> </tr> </thead> <tbody> <tr> <td>Systolic(mm Hg)</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Diastolic(mm Hg) 5th phase</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	BLOOD PRESSURE	1	2	3	Systolic(mm Hg)				Diastolic(mm Hg) 5th phase			
	BLOOD PRESSURE	1	2	3											
	Systolic(mm Hg)														
Diastolic(mm Hg) 5th phase															
5. ABDOMEN a) Are the liver, spleen, kidneys palpable? b) Are there any abnormal abdominal mass , such as hernia, tumour? c) Are there any symptoms of any digestive disturbances?	<input type="checkbox"/>	<input type="checkbox"/>													
6. Are there any diseases of the thyroid or endocrine glands ?	<input type="checkbox"/>	<input type="checkbox"/>													
7. Are there any Ear, Nose or Throat abnormality?	<input type="checkbox"/>	<input type="checkbox"/>													
8. Are there any diseases of the Eyes ? Are there any arcus senilis, xanthoma or any stigma of vascular abnormality?	<input type="checkbox"/>	<input type="checkbox"/>	VISUAL ACUITY * Aided / Unaided												
			<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="width: 50%;">Right</th> <th style="width: 50%;">Left</th> </tr> </thead> <tbody> <tr> <td>Distant</td> <td></td> <td></td> </tr> <tr> <td>Near</td> <td></td> <td></td> </tr> </tbody> </table>		Right	Left	Distant			Near					
		Right	Left												
	Distant														
Near															

		Yes	No	Please give full details of any abnormality					
9. a) GENITOURINARY SYSTEM Are there any diseases of the urinary and genital organs? eg. varicocele, calculus.		<input type="checkbox"/>	<input type="checkbox"/>	Female examinee: to indicate LMP when blood is present					
	b) URINE EXAMINATION Send specimen for microscopic urinalysis if blood (provided not due to menses) or albumin is present or history of urinary disease. If urine sugar is present, to draw blood for HbA1C and blood sugar (to indicate if it's fasting or random)								URINE EXAMINATION
					PH	Albumin	Sugar	Blood	Put cells or other abnormalities
10. a) Does he/she has any visible growth, tumour or enlargement? If so, please state its location and its nature.		<input type="checkbox"/>	<input type="checkbox"/>						
b) Are there any significant changes in his or her appetite, weight and bowel habits recently? If so, please elaborate.		<input type="checkbox"/>	<input type="checkbox"/>						
c) Are you of the opinion that he/she is particularly exposed to the risk of HIV infection?		<input type="checkbox"/>	<input type="checkbox"/>						
d) Are there any further medical or information required to enable a correct judgement of the risk		<input type="checkbox"/>	<input type="checkbox"/>						
11. a) Please furnish his/her height & weight.		Height (cm) _____ Weight (kg) _____							
b) Has the weight *increased, decreased or remained the same during the pass one year?		<input type="checkbox"/>	Increased	<input type="checkbox"/>	Decreased	<input type="checkbox"/>	Stable		
c) Is there any unexplained weight loss? If Yes, please provide reasons for the weight loss.		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No				
12. Please furnish his/her chest and abdomen measurements.		a) Inspiration _____ cm							
a) & b) Circumference of chest at nipple level		b) Expiration _____ cm							
c) Circumference of abdomen at umbilicus		c) Abdomen _____ cm							
13. In the case of a Female :-									
a) Are there any lumps or lesions in the breasts?		<input type="checkbox"/>	<input type="checkbox"/>						
b) Are there any obstetrics or gynaecological abnormalities whether past or present? eg. Fibroid, ovarian cyst etc.		<input type="checkbox"/>	<input type="checkbox"/>						
c) Is she now pregnant? If yes, please give the gestational stage. _____		<input type="checkbox"/>	<input type="checkbox"/>						

B. MEDICAL EXAMINER'S

Please comment and provide any additional information on the examinee that would assist Aviva's assessment of the application.

C. SIGNATURE

Signature of Medical Examiner _____ Name of Medical Examiner _____

Date of Examination

D	D	M	M	2	0	Y	Y
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 Clinic's Stamp _____

* Please delete accordingly

This Report should be sent directly to Group Life & Health Underwriting.