* P R 0 P F *

New Business Health Declaration (for Health Products)

IMPORTANT NOTE:
PURSUANT TO THE INSURANCE ACT (CAP.142), YOU ARE TO DISCLOSE IN THIS FORM FULLY AND FAITHFULLY, ALL FACTS WHICH YOU KNOW OR OUGHT TO KNOW, OTHERWISE, NOTHING MAY BE PAYABLE UNDER THE POLICY.

Contract Number			
Name of Assured		NRIC/FIN Number	
Name of Life Assured		NRIC/FIN Number	

Any disease or condition of health will not qualify for benefit unless it is fully disclosed to and accepted by us. You must 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, 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 **ever** experienced **symptoms** or received **medical advice** or had **treatment** for any of the following conditions (**whether diagnosed or not**)?	
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?	☐ Yes ☐ No
b) High blood pressure or high cholesterol?	☐ Yes ☐ No
c) Cancer, or malignant tumour/growth/lump/nodule/polyp/cyst of any kind including cancer screening tests that were not normal?	☐ Yes ☐ No
d) Benign tumour/growth/lump/nodule/polyp/cyst?	☐ Yes ☐ No
e) Diabetes, elevated or raised blood sugar, thyroid disorders or any other endocrine disease or disorder?	☐ Yes ☐ No
f) Asthma, bronchitis, pneumonia, tuberculosis, emphysema or any other breathing or lung disease or disorder?	☐ Yes ☐ No
g) Depression, anxiety, stress or any other mental or nervous disorder?	☐ Yes ☐ No
h) Drug or alcohol addiction or abuse?	☐ Yes ☐ No
i) Arthritis, gout or any other disorder, pain or injury to the muscles, bones, tendons, limbs, joints, spine (back or neck)?	☐ Yes ☐ No
j) Stroke, epilepsy, fits, paralysis or weakness of limb, head injury or any other neurological disease or disorder?	☐ Yes ☐ No
k) Crohn's disease, ulcerative colitis, stomach or duodenal ulcers, or any other bowel, stomach or intestinal disease or disorder?	☐ Yes ☐ No

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Section A: Health Questions *(continued)*

l)	Hepatitis B or C, fatty liver, jaundice, abnormal or elevated liver function, gallstones or any other liver or gallbladder disease or disorder?	☐ Yes ☐ No
m)	AIDs, HIV or sexually transmitted disease?	☐ Yes ☐ No
n)	Anaemia, thalassaemia, haemophilia or any other blood disease or disorder?	☐ Yes ☐ No
o)	Kidney stones, kidney infection, urine abnormalities or any other kidney, bladder, prostate or gynaecological disease or disorder?	☐ Yes ☐ No
p)	Eye, ear, nose or throat disease or disorder (excluding sight problems corrected by prescription lenses)?	☐ Yes ☐ No
q)	Any other illness, disorder, operation, physical disability, injury or hospitalisation not mentioned above?	☐ Yes ☐ No
4.	For application of life assured who is a dependant child (aged one year and below), please answer the following questions:	
a)	Were there any significant events during pregnancy or delivery of the child including but not limited to difficulties during or at birth, congenital mental developmental issues, respiratory distress syndrome, prolonged neonatal jaundice, respiratory disorder?	☐ Yes ☐ No
b)	Was the child a premature baby (i.e. less than 37 weeks of gestation)?	☐ Yes ☐ No
c)	Has the child been advised or been told to go for further follow up or further evaluation after each routine assessment?	☐ Yes ☐ No
	If you answered **'Yes'** to any of questions 4(a) to (c) above, please provide a full copy of the child's Health Booklet and complete the table below.	

If you answered **'Yes'** to either Question 3 or 4 above, please complete the table below:

Name of **Condition**	Date of **first** symptoms, diagnosis or recurrence	Have you made a **full recovery** with no further treatment, recurrence of condition, ongoing symptoms or complications?	Name and address of **doctor** whom you consulted
Question ( ) Condition:	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more	☐ **Yes** How long has it been since your **full recovery**? ☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more ☐ **No** What **treatment** or **medication** are you taking?	Name: Address:
Name of **Condition**	Date of **first** symptoms, diagnosis or recurrence	Have you made a **full recovery** with no further treatment, recurrence of condition, ongoing symptoms or complications?	Name and address of **doctor** whom you consulted
Question ( ) Condition:	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more	☐ **Yes** How long has it been since your **full recovery**? ☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more ☐ **No** What **treatment** or **medication** are you taking?	Name: Address:

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Section A: Health Questions *(continued)*

Name of **Condition**	Date of **first** symptoms, diagnosis or recurrence	Have you made a **full recovery** with no further treatment, recurrence of condition, ongoing symptoms or complications?	Name and address of **doctor** whom you consulted
Question ( ) Condition:	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more	☐ **Yes** How long has it been since your **full recovery**? ☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more ☐ **No** What **treatment** or **medication** are you taking?	Name: Address:

5. In the **last 5 years**, have you had any **medical test(s) with abnormal results,** such as X-ray, ultrasound, imaging scan, biopsy, electrocardiogram (ECG), blood or urine test, prostate check, pap smear or mammogram? ☐ Yes ☐ No

If '**Yes**', please complete the table below:

Name of medical test	Date of initial test	Have you had a follow-up test ?	Date of follow-up test	Have you been prescribed treatment or been advised to have any further test or required follow-up/monitoring?	Name and address of **doctor** whom you consulted
	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years	☐ Yes ☐ No If '**Yes**', what was the result? ☐ normal ☐ abnormal ☐ don't know	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years	☐ **Yes** ☐ **No** If '**Yes**', please provide details	Name: Address:

Name of medical test	Date of initial test	Have you had a follow-up test ?	Date of follow-up test	Have you been prescribed treatment or been advised to have any further test or required follow-up/monitoring?	Name and address of **doctor** whom you consulted
	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years	☐ Yes ☐ No If '**Yes**', what was the result? ☐ normal ☐ abnormal ☐ don't know	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years	☐ **Yes** ☐ **No** If '**Yes**', please provide details	Name: Address:

6 Are you currently experiencing **symptoms** or **considering** seeking medical advice or treatment for your health other than minor illness such as cold or flu? ☐ Yes ☐ No

If '**Yes**', please complete the table below:

What are the **symptoms** or conditions?	Date of **first** symptoms	Date of any planned medical consultation
	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 year or more	
	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 year or more	

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Section A: Health Questions *(continued)*

7. Have you had an **application, reinstatement** or **renewal** of a Life, Critical Illness, Health, Accident or Disability policy **deferred** or **declined**? If **'Yes'**, please complete the information in the box below:	☐ Yes ☐ No
Name of Insurer : Type of Policy : Reason :	
8. Have you **ever** experienced **symptoms** or received **medical advice** or had **treatment** for any of the following conditions **(whether diagnosed or not)**? • AIDS or HIV infection • Alzheimer's disease • Angioplasty • Any form of Cancer • Atherosclerosis • Autism • Bipolar Disorder • Chronic cor pulmonale • Chronic Kidney disease • Chronic Obstructive lung disease • Coronary Artery Disease (CAD) • Dementia • Diabetes Mellitus /Impaired Glucose tolerance • Down syndrome • Heart attack • Heart bypass • Hepatitis C/D • Ischaemic Heart Disease (IHD) • Kidney failure • Liver cirrhosis • Multiple sclerosis • Muscular Dystrophy • Organ transplant • Osteoporosis • Paralysis • Polycystic Kidney disease • Pulmonary hypertension • Schizophrenia • Stroke • Systemic Lupus Erythematosus (SLE) • Thalassaemia intermediate/major	☐ Yes ☐ No
9. Are you required to pay Additional Premiums for MediShield Life? If **'Yes'**, please *either* provide a copy of the **CPF MediShield Life Additional Premium Letter** to us for underwriting purposes or complete the table below:	☐ Yes ☐ No

Name of **Condition**	Date of **first** symptoms, diagnosis or recurrence	Have you made a **full recovery** with no further treatment, recurrence of condition, ongoing symptoms or complications?	Name and address of **doctor** whom you consulted
Question ( ) Condition:	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more	☐ **Yes** How long has it been since your **full recovery**? ☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more ☐ **No** What **treatment** or **medication** are you taking?	Name: Address:

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Section B: Declaration

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

I/We declare that the information given is true and complete and that I/we have not withheld any material information that may influence the assessment of my/our application.

I/We agree that this declaration will constitute part of my/our application/policy and that failure to disclose any material known fact(s) by me/us may render the contract void from the start and nothing may be payable under the Policy.

I/We consent to Aviva (and Aviva related group of companies) collecting, using and/or disclosing my/our personal data for the processing of the above transaction and such other purposes ancillary or related to the administering of the policy(ies), account(s) and/or managing my/our relationship with Aviva.

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.

Signature of Assured & Date	Signature of Life Assured & Date (who is 16 years old and above)

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