



Respiratory Disorder Supplementary Questionnaire (Q27)

	Particulars of Life Assured						
Naı	me : _						
lde	dentity Card / Passport No. : Contract No. :						
Medical Questions							
1.	What was the diagnosis made by the doctor?						
2.	When was this condition diagnosed?						
3.	Please describe your symptoms (eg coughing, wheezing, shortness of breath, chest tightness):						
	(a)	Date of first occurrence of symptoms:					
	(b)	Number of attacks per year:					
	(c)	Date of last occurrence of symptoms:					
	(d)	Severity and duration of each attack:					
	(e)	Do your symptoms restrict your activities in any way? ☐ Yes ☐ No					
		If 'Yes', please provide details:					
4.	Are	you aware of any specific factor which triggers your symptoms (eg exercise, stress, allergy)?					
		Yes □ No					
	If ' Y	'es', please provide details:					

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5. C	Do you smoke cigarettes or any form of tobacco?							
	□ Yes □ No							
If	f 'Yes', please provide details. Number	day:	Number of y	/ears:				
s. V	What treatment was or has been prescribed by your doctor?							
F	Please tick accordingly and provide details:							
	☐ Oral Medication							
	Name of Medication	Dosage	Frequency	Start Date of Medication	End Date of Medication (if applicable)			
	□ Inhaler							
	Name of inhaler	Dosage	Frequency	Date Of L	ast Treatment			
[☐ Others, please provide details:							
	Please specify date of last treatment (if applicable):							
	Have you undergone any investigations (eg x-ray, pulmonary function test)?							
	□ Yes □ No							
I	If ' Yes ', please provide details:							
	Type of Investigation / Test	Da	ate	Results*				
				☐ Normal	☐ Abnormal			
				☐ Normal	☐ Abnormal			
				☐ Normal	☐ Abnormal			
				☐ Normal	☐ Abnormal			
				☐ Normal	☐ Abnormal			

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Have you ever been admitted	to hospital for this conditi	on?	
□ Yes □ No			
f 'Yes', please provide details	:		
Name of Hospital	Date of Admission	Duration of Stay	Intensive Care U (ICU) or General W
Have you ever taken time off ☐ Yes ☐ No		o this condition?	
-			on of Time-off
☐ Yes ☐ No If ' Yes ', please provide details			on of Time-off
☐ Yes ☐ No If ' Yes ', please provide details			on of Time-off
☐ Yes ☐ No If ' Yes ', please provide details	5:	Duratio	

Note: Please provide us with copies of all medical reports relating to this condition, if available.

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Declaration

I/We agree to inform Aviva Ltd if there is any change in my/our health status between the date of this 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 agree that the above information shall form the basis of my/our application for insurance. I/We declare that the information given is true and complete and I/we have not withheld any material information that may influence the assessment of my/our application.

Name and Signature of Life Assured	Date (dd/mm/yyyy)
Name and Signature of Assured	Date (dd/mm/yyyy)

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