



Cyst / Lump / Tumours / Polyps Supplementary Questionnaire (Q41)

Particulars of Life Assured

Name : _____

Identity Card / Passport No. : _____ Contract No. : _____

Medical Questions

1. What was the diagnosis made by the doctor?

2. Please provide the following details:

Condition (eg cysts / lumps / tumours / polyps)	Site of Cysts / Lumps / Tumours / Polyps	Date First Detected	Number Detected	Number Removed	Benign (non-cancerous) or Malignant (cancerous)

3. Have all the cysts / lumps / polyps / tumours been completely removed?

Yes No

If 'Yes', please provide details:

Date of Surgery	Nature of Surgery	Results

If 'No', do you have any intention to remove it in the future?

Yes No

If 'Yes', please provide scheduled date of surgery: _____

4. Have you undergone any investigation (eg ultrasound / biopsy)?

Yes No

If 'Yes', please provide details:

Type of Investigation / Test	Date	Results*	
		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal

* For abnormal results, please provide details: _____

5. What treatment was or has been prescribed by your doctor?

Please tick accordingly and provide details:

Oral Medication

Name of Medication	Dosage	Frequency	Start Date of Medication	End Date of Medication (if applicable)

Regular Surveillance (eg ultrasound / scan / scope)

Type of Test	Date of Last Test	Results	Date of Next Test

Others, please provide details: _____

Please specify date of last treatment (if applicable): _____

6. Has there been any recurrence since the surgery to remove the cysts / lumps / polyps / tumours?

Yes No

If 'Yes', please provide details and attach a copy of the ultrasound / investigation report:

7. Please provide the name and address of the doctor / clinic / hospital which you have consulted for this condition.

Name of Doctor / Clinic / Hospital	Address	Date of Last Consultation

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

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)