Health Declaration Form for MyMaternityPlan

* P R 0 P F *

AVIVA

WARNING: PURSUANT TO SECTION 25(5) OF THE INSURANCE ACT (CAP.142), YOU ARE TO DISCLOSE IN THIS APPLICATION FORM FULLY AND FAITHFULLY ALL FACTS WHICH YOU KNOW OR OUGHT TO KNOW, OTHERWISE THE INSURANCE EFFECTED MAY BE VOID.

This policy is underwritten by Aviva Ltd and will be entered into the register of Singapore policies. The terms and conditions of this policy shall be governed by and construed in accordance with the laws of Singapore.

Contract No. :
Life Assured/Assured :
Gender / Smoker Status : Age Next Birthday:
Occupation :
Residency / Nationality :

1 GENERAL QUESTIONS

		Life Assured
1.1	What is your **height** and **weight**? **Please provide weight immediately before pregnancy**.	Height : _____ m Weight : _____ kg
1.2	What is the legal basis of your stay in the current country of residence? *If you have selected 'Others' or reside outside of Singapore, please complete the **Residential Questionnaire**.*	☐ Citizen or Permanent Resident ☐ Work Visa or Permit ☐ Employment Pass ☐ Dependent Pass ☐ Others (eg S Pass): _____
1.3	Have you been **residing in Singapore** for more than 183 days in the last 12 months preceding the date of application?	☐ Yes ☐ No

2 OBSTETRICIAN AND GYNAECOLOGISTS DETAILS

Current gestational week	Expected date of delivery (dd/mm/yyyy)	Name and address of Obstetrician and Gynaecologist
1 to 12 weeks – Ineligible ☐ 13 to 17 weeks ☐ 18 to 22 weeks ☐ 23 to 27 weeks ☐ 28 to 32 weeks ☐ 33 to 36 weeks *37 weeks and above - Ineligible*	**Date of last follow-up (dd/mm/yyyy)**	Name: Address:

3 PERSONAL MEDICAL HISTORY QUESTIONS

Have you ever had or received **medical advice** for any of the following illness, or been **referred for tests** or **investigations** for any of these conditions: Heart attack, cardiomyopathy, chest pain, stroke, cancer, raised blood sugar, diabetes, hypertension, mental or nervous illness, epilepsy, autoimmune disease, kidney disease, Hepatitis B or C, liver fibrosis or cirrhosis? If '**Yes**', please complete the following:	**Life Assured** ☐ Yes ☐ No

Name of **Condition**	Date of **first** symptoms or diagnosis	Have you made a **full recovery** with no further treatment, ongoing symptoms or complications?		Name and address of **doctor** whom you consulted
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 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** did you take?	Name: Address:

4 FAMILY HISTORY QUESTION

Have **you** or the **biological father** of the foetus suffers from congenital heart disorder, congenital brain and spinal disorder, congenital deafness, cleft palate and/or lip, renal failure, haemochromatosis or any other hereditary disease such as polycystic kidney, thalassaemia minor/major, haemophilia A, Huntington's disease, muscular dystrophy, cystic fibrosis? If '**Yes**', please complete the following:	**Life Assured** ☐ Yes ☐ No

Name of medical condition	Please indicate self or biological father of the foetus	Age when diagnosed	Age at death (if applicable)

5 PREGNANCY HISTORY QUESTIONS

		Life Assured
5.1	Have you previously conceived? If '**Yes**', please complete all questions under this section 5 and how many child(ren) do you have? If '**No**', please skip this section 5.	☐ Yes ☐ No No. of child(ren)
5.2	Have you had any history of late miscarriage (i.e. after the first trimester)?	☐ Yes ☐ No
5.3	Have you had any complications during your past pregnancy such as gestational diabetes mellitus, hypertension, placental abnormalities, protein in urine, pre-term labour, still birth or any complications not mentioned above? If '**Yes**', please provide details:	☐ Yes ☐ No
5.4	Has any of **your child(ren)** ever been treated for or been told to have: (a) Conditions affecting the eyes, ears or speech? (b) Prematurity, delayed physical or mental development, Spina bifida or Down syndrome? (c) Hole-in-the-heart, Transposition of the great vessels or Tetralogy of Fallot? (d) Any other congenital defects or conditions that require regular follow-up?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

5 PREGNANCY HISTORY QUESTIONS *(continued)*

If you have answered '**Yes**' to any one of **questions 5.4(a) to 5.4(d)**, please complete the following:

CHILD(REN)				
Name of **Condition**	Date of **first** symptoms or diagnosis	Has your child(ren) made a **full recovery** with no further treatment, ongoing symptoms or complications?		Name and address of the **doctor** whom your child(ren) 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 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** did your child(ren) take?	Name: Address:
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 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** did your child(ren) take?	Name: Address:

6 CURRENT PREGNANCY QUESTIONS

		Life Assured
6.1	Have you been advised by a medical doctor not to conceive?	☐ Yes ☐ No
6.2	Have you been told by your doctor to have **excessive pregnancy weight gain**?	☐ Yes ☐ No
6.3	Do you currently smoke? If '**Yes**', how many sticks?	☐ Yes ☐ No ☐ sticks per day
6.4	Is your pregnancy conceived through fertility treatment? If '**Yes**', please select: ☐ In Vitro Fertilisation (IVF) ☐ Intracytoplasmic Sperm Injection (ICSI) ☐ Intrauterine Insemination (IUI) ☐ Intracervical Insemination (ICI) ☐ Others – please specify: _____	☐ Yes ☐ No
6.5	Are you having twins, triplets, quadruplets or more? If '**Yes**', please state the number of foetuses.	☐ Yes ☐ No No. of foetuses: ☐
6.6	Have you been told or have received treatment for any of the following condition(s) during pregnancy:	
	(a) Hypertension, pre-eclampsia (pregnancy induced hypertension with protein in urine), gestational diabetes mellitus?	☐ Yes ☐ No
	(b) Bleeding during pregnancy (after first trimester), placental abnormalities, weakness of cervix or premature uterine contractions?	☐ Yes ☐ No
	(c) Fibroids, severe anaemia (below haemoglobin level of 8 mg/dl) or low platelet counts?	☐ Yes ☐ No
	(d) Fatty liver due to pregnancy?	☐ Yes ☐ No
	(e) Any other pregnancy complications that are not mentioned above?	☐ Yes ☐ No

6 CURRENT PREGNANCY QUESTIONS *(continued)*

6.7	Have you had any hospitalisation during this pregnancy?	☐ Yes ☐ No
6.8	Have you been told of any abnormality of the foetus (e.g. Down syndrome, abnormal foetal size, abnormal heart rate or any congenital abnormality)?	☐ Yes ☐ No

If you have answered '**Yes**' to any one of **questions 6.6 to 6.8**, please complete the following:

Name of **Condition**	Have you made a **full recovery** with no further treatment, ongoing symptoms or complications?		Name and address of **doctor** whom you consulted
Question ( ) Condition:	☐ **Yes**	☐ **No** What **treatment** or **medication** did you take?	Name: Address:
Question ( ) Condition:	☐ **Yes**	☐ **No** What **treatment** or **medication** did you take?	Name: Address:

		Life Assured
6.9	Have you done or been advised to do Amniocentesis or chorionic villous sampling?	☐ Yes ☐ No
6.10	Have you been told to have abnormal ultrasound scan or any other abnormal medical test results?	☐ Yes ☐ No
6.11	Are you currently waiting for results of any tests or investigations?	☐ Yes ☐ No

If you have answered '**Yes**' to any one of **questions 6.9 to 6.11**, please complete the following and submit a copy of the above test(s)/investigations(s), if any.

Exact Diagnosis	Details of Investigations (type of tests, dates and results)	Details of treatment	Name and address of **doctor** whom you consulted
			Name: Address:

DECLARATION

I declare that my spouse/I have purchased one of the basic plans (which is available at point of my purchase of MyMaternityPlan)* insuring him/me and I have opted to purchase MyMaternityPlan.

*Please refer to www.aviva.com.sg/MyMaternityPlan for the full list of available basic plans.

Important Notes:
If a material fact is not disclosed in this application, any policy issued may not be valid. If you are in doubt as to whether a fact is material, you are advised to disclose it. This includes any information that you may have provided to the Financial Adviser Representative but was not included in the application. Please check to ensure you are fully satisfied with the information declared in this application.

Signed and declared in SINGAPORE on (DD/MM/YYYY) _____

Signature of Life Assured : _____

Name : _____

Identity Card / Passport No. : _____

Signature of Financial Adviser Representative : _____

Name : _____

Signature of Proposer (Assured) / Joint Life Assured : _____

Name : _____

Identity Card / Passport No. : _____