



HEALTH DECLARATION FORM

WARNING: PURSUANT TO SECTION 23(5) OF THE INSURANCE ACT 1966, YOU ARE TO DISCLOSE IN THIS APPLICATION FORM FULLY AND FAITHFULLY ALL THE FACTS WHICH YOU KNOW OR OUGHT TO KNOW, OTHERWISE THE INSURANCE EFFECTED MAY BE VOID.

This policy is underwritten by Singapore Life 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.	<input type="text"/>
Life Assured/Assured	<input type="text"/>
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female Smoker Status <input type="checkbox"/> Yes <input type="checkbox"/> No
Occupation	<input type="text"/> Residency/Nationality <input type="text"/>
Age Next Birthday	<input type="text"/>

SECTION 1: GENERAL QUESTIONS

LIFE ASSURED

1.1 What is your height and weight ? Please provide weight immediately before pregnancy.	Height (m) <input type="text"/> Weight (kg) <input type="text"/>
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 .	<input type="checkbox"/> Citizen or Permanent Resident <input type="checkbox"/> Work Visa or Permit <input type="checkbox"/> Employment Pass <input type="checkbox"/> Dependent Pass <input type="checkbox"/> Others (eg S Pass): <input type="text"/>
1.3 Have you been residing in Singapore for more than 183 days in the last 12 months preceding the date of application?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 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 <input type="checkbox"/> 13 to 17 weeks <input type="checkbox"/> 18 to 22 weeks <input type="checkbox"/> 23 to 27 weeks <input type="checkbox"/> 28 to 32 weeks <input type="checkbox"/> 33 to 36 weeks 37 weeks and above - Ineligible	<input type="text"/> Date of last follow-up (dd/mm/yyyy) <input type="text"/>	Name: Address: <input type="text"/>

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SECTION 3: PERSONAL MEDICAL HISTORY QUESTIONS

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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:

 Yes No

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:

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: <input type="text"/>	<input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years <input type="checkbox"/> 5 years or more	<input type="checkbox"/> Yes How long since your full recovery ? <input type="checkbox"/> 0 - 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years <input type="checkbox"/> 5 years or more		<input type="checkbox"/> No What treatment or medication did you take? <input type="text"/>
				Name: Address:

SECTION 4: FAMILY HISTORY QUESTION

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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?

 Yes No

If 'Yes', please complete the following:

Name of medical condition	Please indicate self or biological father of the foetus	Age when diagnosed	Age at death (if applicable)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

SECTION 5: PREGNANCY HISTORY QUESTIONS

LIFE ASSURED

5.1 Have you previously conceived?

 Yes No

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.

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?

 Yes No

If 'Yes', please provide details:

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?

 Yes No

(b) Prematurity, delayed physical or mental development, Spina bifida or Down syndrome?

 Yes No

(c) Hole-in-the-heart, Transposition of the great vessels or Tetralogy of Fallot?

 Yes No

(d) Any other congenital defects or conditions that require regular follow-up?

 Yes No

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SECTION 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: <input type="text"/>	<input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years <input type="checkbox"/> 5 years or more	<input type="checkbox"/> Yes How long since your full recovery ? <input type="checkbox"/> 0 - 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years <input type="checkbox"/> 5 years or more		<input type="checkbox"/> No What treatment or medication did your child(ren) take? <input type="text"/>	Name: Address:
Question: () Condition: <input type="text"/>	<input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years <input type="checkbox"/> 5 years or more	<input type="checkbox"/> Yes How long since your full recovery ? <input type="checkbox"/> 0 - 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years <input type="checkbox"/> 5 years or more		<input type="checkbox"/> No What treatment or medication did your child(ren) take? <input type="text"/>	Name: Address:

SECTION 6: CURRENT PREGNANCY QUESTIONS

LIFE ASSURED

6.1 Have you been advised by a medical doctor not to conceive?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.2 Have you been told by your doctor to have excessive pregnancy weight gain ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.3 Do you currently smoke? If 'Yes', how many sticks?	<input type="checkbox"/> Yes <input type="checkbox"/> No Sticks per day _____
6.4 Is your pregnancy conceived through fertility treatment? If 'Yes', please select: <input type="checkbox"/> In Vitro Fertilisation (IVF) <input type="checkbox"/> Intracytoplasmic Sperm Injection (ICSI) <input type="checkbox"/> Intrauterine Insemination (IUI) <input type="checkbox"/> Intracervical Insemination (ICI) <input type="checkbox"/> Others – please specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.5 Are you having twins, triplets, quadruplets or more? If 'Yes', please state the number of foetuses.	<input type="checkbox"/> Yes <input type="checkbox"/> 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? (b) Bleeding during pregnancy (after first trimester), placental abnormalities, weakness of cervix or premature uterine contractions? (c) Fibroids, severe anaemia (below haemoglobin level of 8 mg/dl) or low platelet counts? (d) Fatty liver due to pregnancy? (e) Any other pregnancy complications that are not mentioned above?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No

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SECTION 6: CURRENT PREGNANCY QUESTIONS *(continued)*

6.7 Have you had any hospitalisation during this pregnancy?		<input type="checkbox"/> Yes	<input type="checkbox"/> 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)?		<input type="checkbox"/> Yes	<input type="checkbox"/> 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: ()	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Condition:		What treatment or medication did you take?	Name:		
<input type="text"/>		<input type="text"/>	Address:		
Question: ()	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Condition:		What treatment or medication did you take?	Name:		
<input type="text"/>		<input type="text"/>	Address:		
LIFE ASSURED					
6.9 Have you done or been advised to do Amniocentesis or chorionic villous sampling?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
6.10 Have you been told to have abnormal ultrasound scan or any other abnormal medical test results?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
6.11 Are you currently waiting for results of any tests or investigations?		<input type="checkbox"/> Yes	<input type="checkbox"/> 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
<input type="text"/>	<input type="text"/>		<input type="text"/>		Name:
					Address:

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DECLARATION

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

*Please refer to www.singlife.com/singlife-maternity-care 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.

AT THE TIME OF YOUR BABY'S BIRTH, IF ANY OUTSTANDING REQUIREMENT AND/OR PREMIUM FOR YOUR APPLICATION HAS NOT BEEN FULFILLED AND/OR RECEIVED RESPECTIVELY, YOUR POLICY WILL NOT BE ISSUED. IF ISSUED, THE POLICY WILL BE NULL AND VOID.

	Signature of Proposer (Assured)/Joint Life Assured	Signature of Financial Adviser Representative
Name <input style="width: 90%;" type="text"/>	Name <input style="width: 90%;" type="text"/>	Name <input style="width: 90%;" type="text"/>
Identity Card/ Passport No.: <input style="width: 90%;" type="text"/>	Identity Card/ Passport No.: <input style="width: 90%;" type="text"/>	
Signed and declared in SINGAPORE on (DD/MM/YY) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>		