Group Life & Health Underwriting

Policy No.:

MEDICAL EXAMINATION FORM

IMPORTANT NOTE: Pursuant to Section 23(5) of the Insurance Act 1966, 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.

PART (I) - PERSONAL STATEMENT BY THE EXAMINEE

A. PARTICULARS OF EXAMINEE (Please complete in capital letters)

*** Please delete accordingly**

*NRIC/Passport/BC No.

Date of Birth(ddmmyyyy)

Age Next Birthday

Full name as shown on NRIC/Passport/BC (Underline Surname)
*Mr/Mrs/Mdm/Ms/Dr

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Country of Residence: _____ Nationality: _____

Residential Address:

Postal Code

Occupation and Exact Nature of Duties:

Name of Company:

Tel No.
(H):
(O):

Email Address:

B. PLEASE ANSWER THE FOLLOWING QUESTIONS (To be answered by the Examinee)

1a. Do you have a regular doctor? Yes ☐ No ☐
If yes, please state name and address of your regular doctor.

1b. Please state the type of illness consulted, date of consultations and the results of such consultations with your regular doctor.

	Yes	No	If "Yes", please give details such as date of onset/test, names & address of doctor, results of investigation, type of treatment, any recurrence/fully recovered
2. Are you now receiving, or considering to receive medical treatment from a doctor or any intention to consult any doctor for any reason, seek further treatment or alternative medicine?	☐	☐	
3. Have you ever undergone any special investigation such as X-RAY, ultrasound, electrocardiogram, mammogram, blood or urine tests etc. in the past 5 years? (Please state date, reason, type and result of tests done.)	☐	☐	
4. Have you ever had , or been told to have or been treated for: -	Yes	No	If "Yes", please give details such as date of onset/test, names & address of doctor, results of investigation, type of treatment, any recurrence/fully recovered
a. Epilepsy/ fits, stroke, paralysis/ weakness of limb, prolonged headache, nervous breakdown, depression or any other nervous/ mental disorders?	☐	☐	
b. Cataract, ear infection/ discharge or any other disorders of eye, ear, nose or throat?	☐	☐	
c. Asthma, bronchitis, persistent cough, coughing with blood pneumonia, tuberculosis, breathing complaints/ discomfort or any other lung disorders?	☐	☐	
d. Raised cholesterol, high blood pressure, heart attack, mitral valve prolapse or other heart valve disorders, breathlessness, fast heart rate, chest pain or any disease or disorders of the heart?	☐	☐	
e. Diabetes mellitus, thyroid disorder or any endocrine disease?	☐	☐	
f. Gastritis, stomach or duodenal ulcer, blood in stools, fistula, piles or any other stomach or bowel disorder?	☐	☐	

	Yes	No	If "Yes", please give details such as date of occurrence, investigation / treatment provided and name / address of doctor.
g. Jaundice, Hepatitis B carrier or any form of hepatitis, liver or gallbladder disorder?	☐	☐	
h. Blood, protein or sugar in urine, kidney stones, infection, or any other disorders of the kidney, bladder or genital organs?	☐	☐	
i. Cancer, tumour, cyst or growth of any kind?	☐	☐	
j. Slipped disc, backache, gout, arthritis, pain or deformity or disorders of the muscles, spine, limbs or joints or severe injury?	☐	☐	
k. Any sexually transmitted disease, eg: syphilis, gonorrhea, non-specific urethritis, herpes, HIV Infection or AIDS?	☐	☐	
l. Endometriosis, fibroids, cysts, breast lumps, abnormal pap smear, irregular or painful menstruation, or any other disorders of the female organs?	☐	☐	
m. Anemia, hemophilia or any disorders of the blood?	☐	☐	
n. Any other illnesses, congenital or hereditary disorders, any hospitalization or physical injuries not listed above?	☐	☐	
5. Have you ever received any blood transfusion or ever been refused as a donor?	☐	☐	
6. Have you smoked cigarettes in the past 12 months? If "YES", please state number of years and sticks smoked per day.	☐	☐	No. of Years No. of sticks/day
7. Do you consume alcohol? If "YES", please state the quantity, type and frequency.	☐	☐	Quantity Type Frequency
8. Do you engage in hazardous activities such as aviation (other than as a private paying passenger), scuba diving, motor racing, mountaineering, etc.?	☐	☐	
9. Do you engage in activities that will increase exposure to AIDS or AIDS related conditions?	☐	☐	
10. Have any of your natural parents or siblings died or suffered from a. Heart Disease b. High Blood Pressure c. Stroke d. Diabetes e. Cancers f. Kidney Disease g. Mental Disorder h. Muscular or any other hereditary disease?	☐	☐	

Relationship	Condition/ Cause of Death	Age at onset	If deceased, Age at Death

C. PERSONAL DATA CONSENT(S)

On behalf of myself and my dependents, I/we consent to Singapore Life Ltd. ("Singlife") (and Singlife 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 Singlife.

On behalf of myself and my dependents, I/we also consent to Singlife (and Singlife related group of companies) disclosing and transferring my/our personal data to Singlife (and Singlife related group of companies) and their respective third party service providers, reinsurers, suppliers or intermediaries, whether located in Singapore or elsewhere, for the above purposes.

On behalf of myself and my dependents, I/we have read and understood Singlife's Data Protection Notice which may be found at www.singlife.com/pdpa. Singlife's Data Protection Notice may be updated from time to time without notice. I/We am/are aware that I/we should visit your website regularly to ensure that I/we am/are well informed of the updates.

D. DECLARATION

I declare that the answers were given by me in reply to the questions put to me and to the best of my knowledge and belief, the information furnished in here are true and complete and I agree that they are in continuation of and form part of my proposal and that failure to disclose any material known fact to me may invalidate the Policy. I agree to inform Singapore Life Ltd if there is any change in the state of my health or my activities between the date of this Health Declaration/ Medical Examination and the date full insurance coverage is provided by Singapore Life Ltd to me. I understand that the terms of accepting me as a risk for insurance coverage may vary according to such information received. I authorize any medical source, insurance office or organization to release to Singapore Life Ltd and similarly Singapore Life Ltd to release to any of the prior mentioned organizations, relevant information concerning me at any time, irrespective of whether the proposal is accepted by Singapore Life Ltd. A photographic copy of this authorization shall be as valid as the original.

Only applicable to Group Term Life and Medical products (including Livingcare & Disability Income) for all voluntary and flexible benefits.
I/We confirm that I/We have received a copy of Your Guide & Health Insurance for product summary and have read and understood the contents of these two documents.

Signature of Examinee / Date (dd/mm/yyyy)

Signature of Medical Examiner / Date(dd/mm/yyyy)

(PART II) - MEDICAL EXAMINER'S CONFIDENTIAL REPORT

This examination should be in private, without the presence of a third party except as chaperon or interpreter. The medical examiner is requested to send this report in a sealed envelope as it is strictly confidential between the company and the examiner. Please note that we may be obliged to disclose results of the medical examination to the examinee at his request.

A. PLEASE ANSWER THE FOLLOWING QUESTIONS (To be answered by the Medical Examiner)

***Please delete accordingly**

	Yes	No	Please give full details of any abnormality
1. Are you personally acquainted with the examinee? If so, in what capacity and please provide details of any consultations?	☐	☐	
2. CNS, SKELETAL SYSTEM a. Are there any diseases of the central or peripheral nervous system? b. Are the tendon reflexes abnormal? c. Any paralysis or tremors? d. Any bones or joints deformity, amputation?	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	
3. CHEST a. Are the shape, capacity & expansion of the chest unsatisfactory? b. Are the breath sounds abnormal? If not, please describe the adventitious sounds heard.	☐ ☐	☐ ☐	
4. HEART a. Is the Apex beat abnormal? b. Are there any signs of hypertrophy or dilation? c. Are there any abnormalities in the heart sounds? d. Are there any murmurs? If Yes, please indicate the grade of murmurs. e. Blood pressure-if SBP>140 or DBP>90 (5th phase), please take 2 further readings with interval of 5minutes. If the examinee is hypertensive, please state the previous readings with relevant dates, if known.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	**PULSE RATE** beats/minute: ***Regular/Irregular** ☐ **BLOOD PRESSURE** / 1 / 2 / 3 Systolic (mm Hg) Diastolic(mmHg) 5th phase
5. ABDOMEN a. Are the liver, spleen, kidneys palpable? b. Are there any abnormal abdominal mass, such as hernia, tumour? c. Are there any symptoms of any digestive disturbances?	☐ ☐ ☐	☐ ☐ ☐	
6. Are there any diseases of the **thyroid** or **endocrine glands?**	☐	☐	
7. Are there any **Ear, Nose** or **Throat** abnormality?	☐	☐	
8. Are there any diseases of the **Eyes?** Are there any arcus senilis, xanthoma or any stigma of vascular abnormality?	☐	☐	**VISUAL ACUITY* Aided / Unaided** / Right / Left Distant Near

	Yes	No	Please give full details of any abnormality
9. a. **GENITOURINARY SYSTEM** Are there any diseases of the urinary and genital organs? e.g. varicocele, calculus	☐	☐	Female examinee: to indicate LMP when blood is present
b. **URINE EXAMINATION** Send specimen for microscopic urinalysis if blood (provided not due to menses) or albumin is present or history of urinary disease. If urine sugar is present, to draw blood for HBAIC and blood sugar (to indicate if its fasting or random)	☐	☐	**URINE EXAMINATION** PH | Albumin | Sugar | Blood | Pus cells or other abnormalities | | | | |
10. a. Does he/she have any visible growth, tumour or enlargement? If so, please state its location and its nature.	☐	☐	
b. Are there any significant changes in his or her appetite, weight and bowel habits recently? If so, please give details.	☐	☐	
c. Are you of the opinion that he/she is particularly exposed to the risk of HIV Infection?	☐	☐	
d. Are there any further medical or information required to enable a correct judgement of the risk?	☐	☐	
11. a. Please furnish his/her height & weight.	Height (m):		Weight (kg):
b. Has the weight increased, decreased or remained the same during the past one year?	☐ Increased	☐ Decreased	☐ Stable
c. Is there any unexplained weight loss? If Yes, please provide reasons for the weight loss.	☐ Yes	☐ No	
12. Please furnish his/her chest and abdomen measurements. a. & b. Circumference of chest at nipple level c. Circumference of abdomen at umbilicus level	a. Inspiration _____ cm b. Expiration _____ cm c. Abdomen _____ cm		
13. In the case of a Female: - a. Are there any lumps or lesions in the breasts?	☐	☐	
b. Are there any obstetrics or gynaecological abnormalities whether past or present? Eg. Fibroid, ovarian cyst etc.	☐	☐	
c. Is she now pregnant? If yes, please give the gestational stage. _____	☐	☐	

B. MEDICAL EXAMINER'S REMARKS

Please comment and provide any additional information on the examinee that would assist Singapore Life Ltd's assessment of the application.

C. SIGNATURE

Signature of Medical Examiner: _____ Name of Medical Examiner: _____

Date of Examination (dd/mm/yyyy): _____ Clinic's stamp: _____

This report should be sent directly to Singapore Life Ltd, Group Life & Health Underwriting.

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