General Health Supplementary (Q36)

QUESTIONNAIRE

* Q U E S T *

Singlife

SECTION A: PARTICULARS OF LIFE ASSURED

Name

Identity Card / Passport No. | Contract No.

SECTION B: MEDICAL QUESTIONS

1. Please state the diagnosis made by the doctor.

2. When was this condition diagnosed?

3. Have you made a full recovery with no ongoing symptoms or treatment required?

☐ Yes ☐ No

If **'Yes'**, how long has it been since your full recovery?

If **'No'**, how often do you experience symptoms and what are the symptoms?

4. 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)

☐ **Others,** please provide details

Please specify date of last treatment (if applicable)

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5. How frequent is your condition monitored or checked by your doctor?

6. Have you undergone any investigations or tests as a result of this condition?

☐ Yes ☐ No

If **'Yes'**, please provide details:

Type of Investigation / Test	Date	Results*
		☐ Normal ☐ Abnormal
		☐ Normal ☐ Abnormal
		☐ Normal ☐ Abnormal
		☐ Normal ☐ Abnormal
		☐ Normal ☐ Abnormal

* For abnormal results, please provide details

7. Are there any further investigations, tests, treatment or surgery planned?

☐ Yes ☐ No

If **'Yes'**, please provide details:

Date	Details

8. Do you have any complications as a result of your condition?

☐ Yes ☐ No

If **'Yes'**, please provide details

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9. Have you ever been admitted to hospital or had outpatient follow-up for this condition?

☐ Yes ☐ No

If **'Yes'**, please provide details:

Name of Hospital	Date of Admission	Duration of Stay	Date of Last Follow-up

10. Have you taken time off work or school due to this condition?

☐ Yes ☐ No

If **'Yes'**, please provide details:

Date	Duration of Time-off

11. 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.

SECTION C: DECLARATION

I/We agree to inform Singapore Life 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 Singapore Life 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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