



# QUESTIONNAIRE

## SECTION A: PARTICULARS OF LIFE ASSURED

Name

Identity Card / Passport No.  Contract No.

## SECTION B: MEDICAL QUESTIONS

1. What was the diagnosis made by the doctor?

2. When was this condition diagnosed?

3. Please provide details of your symptoms:

Symptoms	Number of Attacks Since First Occurrence	Start Date of Symptoms	Duration of Symptoms

4. What were the triggering factors or situation which triggers or exacerbates your symptoms or condition?

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)

**Others**, please provide details

Please specify date of last treatment (if applicable)

6. Have you ever received psychotherapeutic therapy?

Yes  No

If 'Yes', please provide details

7. Have you ever received electroconvulsive therapy (ECT)?

Yes  No

If 'Yes', please provide details

8. Have you ever had treatment as a hospital out-patient or seen a psychiatrist?

Yes  No

If 'Yes', please provide details:

Name of Institution/Doctor	Type of Treatment Received	Date of Treatment

9. Have you ever been an in-patient at a hospital?

Yes  No

If 'Yes', please provide details:

Date of Admission	Name of Doctor / Psychiatrist	Name of Hospital	Period of Hospitalisation

10. Have you ever had any suicidal ideas, tendencies or actual suicide attempts?

Yes  No

If 'Yes', please provide details:

Date of Occurrence	Follow-up Treatment

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

Yes     No

If 'Yes', please provide details:

Date	Duration of Time-off

12. 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)