



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. Please provide the following details:

| Condition (eg cysts / lumps / tumours / polyps) | Site of Cysts / Lumps / Tumours / Polyps | Date First Detected | Number Detected | Number Removed | Benign (non-cancerous) or Malignant (cancerous) |
|-------------------------------------------------------|------------------------------------------------|------------------------|--------------------|-------------------|----------------------------------------------------------|
| | | | | | |
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| | | | | | |
| | | | | | |

3. Have all the cysts / lumps / polyps / tumours been completely removed?

Yes No

If 'Yes', please provide details:

| Date of Surgery | Nature of Surgery | Results |
|-----------------|-------------------|---------|
| | | |
| | | |
| | | |
| | | |
| | | |

If 'No', do you have any intention to remove it in the future?

Yes No

If 'Yes', please provide scheduled date of surgery

4. Have you undergone any investigation (eg ultrasound / biopsy)?

Yes No

If 'Yes', please provide details:

| Type of Investigation / Test | Date | Results* | |
|------------------------------|------|---------------------------------|-----------------------------------|
| | | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| | | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| | | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| | | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| | | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |

* For abnormal results, please provide details:

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) |
|--------------------|--------|-----------|--------------------------|----------------------------------------|
| | | | | |
| | | | | |

Regular Surveillance (eg ultrasound / scan / scope)

| Type of Test | Date of Last Test | Results | Date of Next Test |
|--------------|-------------------|---------|-------------------|
| | | | |
| | | | |

Others, please provide details

Please specify date of last treatment (if applicable)

6. Has there been any recurrence since the surgery to remove the cysts / lumps / polyps / tumours?

Yes No

If 'Yes', please provide details and attach a copy of the ultrasound / investigation report:

7. 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)