



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. Have you had an ECG, X-ray, blood lipids test, echocardiogram or any other investigations done?

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:

4. Please indicate your latest lipids profile test results and attach a copy of the results.

Date of Test

Lipid Profile Test	Results (mg/dl or mmol/l)
Total Cholesterol	
Triglycerides	
High Density Lipoprotein (HDL)	
Low Density Lipoprotein (LDL)	

5. Do you smoke cigarettes or any form of tobacco?

Yes No

If 'Yes', please provide details. Number of sticks per day Number of years

6. 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)

Other, please provide details

Please specify date of last treatment (if applicable)

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)