

HIGH BLOOD PRESSURE/HIGH CHOLESTEROL QUESTIONNAIRE

HEALTH INSURANCE

Particulars of Life to be Assured

| | | |
|---|---------------------|-------------------|
| Name of Life to be Assured (as shown in NRIC) | Proposal/Policy No. | NRIC/Passport No. |
|---|---------------------|-------------------|

Questions

1. What conditions are you suffering from?

High Blood Pressure

| | |
|-------------------------|--|
| Date of Diagnosis/Onset | |
| Underlying Cause | |

High Cholesterol

| | |
|-------------------------|--|
| Date of Diagnosis/Onset | |
| Underlying Cause | |

2. In the last 2 years did you ever experience symptoms like chest pain, palpitations, dizziness, shortness of breath and reduced physical ability?

Yes (Please give details below) No

| | |
|--------------|--|
| Give Details | |
|--------------|--|

3. Have you ever been hospitalised before?

Yes (Please give details below) No
Please enclose a copy of inpatient discharge/clinical summary(ies). Enclosed Not available

| Date/Period of Hospitalisation | Reason/Diagnosis | Name of Hospital |
|--------------------------------|------------------|------------------|
| | | |
| | | |
| | | |
| | | |

4. Are you on regular follow-up with a doctor?

Yes (Please indicate frequency below by ticking the most suitable one and provide name and address of doctor) No

| | |
|---|-----------------------------|
| <input type="checkbox"/> At least once every 3 months | Name and address of doctor: |
| <input type="checkbox"/> At least once every 6 months | |
| <input type="checkbox"/> Occasionally | |
| <input type="checkbox"/> Never | |

5. What treatment has been prescribed by your doctor?

Diet only
 Diet and Medications. Please give details of the medications you are/were taking.

| Name of Medication | Dosage | Date/Period |
|--------------------|--------|-------------|
| | | |
| | | |
| | | |
| | | |

GH/G6113/HBP/HCQ/09/2009

6. Please provide your blood pressure/cholesterol level readings requested below:

| | Date Measured | Blood Pressure Readings | Cholesterol Level Readings |
|--------------|---------------|-------------------------|--|
| Latest | | Systolic/Diastolic | Cholesterol Triglycerides HDL Cholesterol LDL Cholesterol Chol/HDL Ratio |
| 3 months ago | | Systolic/Diastolic | Cholesterol Triglycerides HDL Cholesterol LDL Cholesterol Chol/HDL Ratio |
| 1 year ago | | Systolic/Diastolic | Cholesterol Triglycerides HDL Cholesterol LDL Cholesterol Chol/HDL Ratio |

7. Any investigation (e.g. ECG, blood test, etc.)/health screening performed?

- Yes (Please give details below) No
 Please enclose a copy of the medical reports. Enclosed Not available

| Type | Date Performed | Result |
|------|----------------|--------|
| | | |
| | | |
| | | |

8. Do you smoke cigarettes? If yes, how many per day?

- Yes. Number of cigarettes per day _____ No

9. Have you ever suffered from any of the following? No

Tick the ones which you have.

- Heart problem Liver problem Kidney problem/ Urine abnormalities
 Stroke Diabetes Mellitus Others

Give Details

Declaration

I declare that the answers I have given are, to the best of my knowledge, true and that I have not withheld any material information that may influence the assessment or acceptance of my proposal.

I agree that this form will constitute part of my proposal for health insurance and that failure to disclose any material fact known to me may invalidate the contract of insurance.

I confirm that there has been no change in my/Life to be Assured's health status since the completion of the application forms including all questionnaires/additional declarations made in connection with the application.

Signed in Singapore on the _____ day of _____ 20____

Signature of Life to be Assured

Signature of Proposer (if different from Life to be Assured)