

INJURY QUESTIONNAIRE

HEALTH INSURANCE (Please complete ONE questionnaire for each injury declared.)

Particulars of Life to be Assured

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

1. Description

a) What injury(ies) did you sustain, on which part(s) of body and how did you sustain the injury(ies)?

Diagnosis / Description of injury(ies) sustained	
Which part(s) of the body (left or right or both) was affected?	
Date (dd/mm/yy) and Nature of Accident	

b) Experienced any resulting symptom/disability (e.g. pain, limping, numbness, etc)?

Yes (Please give details below) No

Description of Symptoms/Disability(ies)			
Date of first occurrence		Date of last occurrence	

What is the nature of the symptom/disability (tick one only)

Acute i.e. one-off Recurrent. Indicate frequency: (tick one only)
 At least 4 times a year At least 2 times a year Once a year
 Chronic i.e. persisting over a long period of time Less often than once a year Others _____

c) Any investigation (e.g. X-ray, blood test, ECG, etc.) performed?

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

Type	Date Performed	Result

2. Treatment

a) Have you seen a doctor?

Yes (Please give details below) No

Name and Address of Doctor	Date of first consultation	Date of last consultation	Result of last consultation

b) Admitted to hospital before?

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

Date/Period of Hospitalisation	Name of Hospital	Result/Outcome

GH/G6113/IQ/09/2009

c) Any Surgery performed and/or metal pieces/screws/plates inserted or removed from which part(s) of body?

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

Type of surgery/metal pieces inserted/removed	Date	Outcome

d) Any Medications, Therapy or Other treatment prescribed by your doctor?

- Yes (Please give details below)
 No

Name/Description	Dosage	Date/Period

3. Current Status

Tick the ones that are applicable and give the required details.

- Have Fully Recovered on _____ (dd/mm/yyyy)
 i.e. NO symptom, NO resulting disability/deformity or restriction in movements/activities, and fully discharged from medical follow-up.

- Still on Regular Medical Follow-up with the doctor

Frequency	
Date of last consultation	
Name and Address of Doctor	

- Waiting for further Investigation or waiting for Treatment/Surgery/metal pieces, screws, plates to be removed

Planned Date	
Description	
Name and Address of Doctor	

- 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)