income made different

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an NTUC Social Enterprise

Supplementary health questionnaire

For official use

Adviser's name	Adviser's code

Details of proposer and insured

Name of proposer (as shown in NRIC)	NRIC number or FIN	Proposal number
Name of insured (as shown in NRIC) (if different from proposer)	NRIC number or FIN	

Details on previous and concurrent applications and claims

	Proposer	Insured
1 Has any application for a life or critical illness or disability, or accident or hospital insurance policy ever been refused, postponed or accepted at special rates with Income or any other insurer?	☐ Yes ☐ No	☐ Yes ☐ No
2 Are you making or have you made any claims, including hospitalisation claims on any policy with Income or any other insurer?	☐ Yes ☐ No	☐ Yes ☐ No

If you answered yes to questions 1 to 2 above, please give details below.
Proposer

Question number	Details

Insured (to fill below if insured is different from proposer)

Question number	Details

Lifestyle

	Proposer	Insured
1 Do you drink alcohol or take any other stimulants?	☐ Yes ☐ No	☐ Yes ☐ No
2 Have you smoked cigarettes in the past 12 months?	☐ Yes ☐ No	☐ Yes ☐ No
3 Do you plan to live abroad for more than three months other than for holidays or studies? If you answered yes, please give details below including the country, for how long and the reason.	☐ Yes ☐ No	☐ Yes ☐ No
4 Do you take part in or do you plan to take part in military or private flying other than as a passenger on a regular airline or any other dangerous occupation or pursuits such as scuba diving, mountain or rock climbing, free-fall parachuting, sky diving or motor racing?	☐ Yes ☐ No	☐ Yes ☐ No
5 Have you been taking any drugs which can become addictive or have you ever been treated for drug or alcohol addiction?	☐ Yes ☐ No	☐ Yes ☐ No

If you answered yes to any of the questions above, please give details below.
Proposer

Question number	Details
1	Quantity per week: Beer _____ cans Wine _____ glasses Spirits _____ tots 1 standard alcoholic drink equates to a 330ml can of beer, a 125ml glass of wine or a 30ml tot of spirits Other stimulants (please state type and quantity) _____
2	Number of years smoked _____ Number of cigarettes per day _____

Lifestyle (continued)

Insured (to fill below if insured is different from proposer)

Question number	Details
1	Quantity per week: Beer _____ cans Wine _____ glasses Spirits _____ tots 1 standard alcoholic drink equates to a 330ml can of beer, a 125ml glass of wine or a 30ml tot of spirits Other stimulants (please state type and quantity) _____
2	Number of years smoked _____ Number of cigarettes per day _____

Family history

	Proposer	Insured
Have either of your natural parents or any of your brothers or sisters died or suffered from cancer including carcinoma in situ, heart disease, stroke, high blood pressure, diabetes, kidney diseases, mental disorder, tuberculosis or any hereditary disease? If you answered yes, please give details below.	☐ Yes ☐ No	☐ Yes ☐ No

Proposer

Relationship to insured	Age	Medical condition	Age when it began	Age at death	Cause of death and details

Insured (to fill below if insured is different from proposer)

Relationship to insured	Age	Medical condition	Age when it began	Age at death	Cause of death and details

Details of doctor (part 1)

	Proposer	Insured
Do you have a regular doctor? If you answered yes, please give details below.	☐ Yes ☐ No	☐ Yes ☐ No

	Proposer	Insured
Name of doctor		
Address		

Details of doctor (part 2)

	Proposer	Insured
Have you consulted any doctor in the last 5 years for conditions other than common cough and flu? If you answered yes, please give details below. To clarify, you can indicate the same doctor as the regular doctor you have given above.	☐ Yes ☐ No	☐ Yes ☐ No

	Proposer	Insured
Name of doctor		
Address		
Date last consult		
Reason for consultation		
Result of last consultation		

Questions on health

	Proposer	Insured
1 Have you ever had, been told to have, been treated for, been told to get treatment for or suffered symptoms of any of the following:		
a epilepsy, fits, stroke, paralysis, weakness of limbs, persistent headache, unconsciousness, nervous breakdown, depression or any other nervous or mental disorder?	☐ Yes ☐ No	☐ Yes ☐ No
b diabetes, thyroid disorders or any other endocrine disorders?	☐ Yes ☐ No	☐ Yes ☐ No
c double vision, impaired sight, hearing or speech, ear discharge, nosebleeds or any other disorders of the eye, ear, nose or throat?	☐ Yes ☐ No	☐ Yes ☐ No
d asthma or a persistent cough, coughing with blood, pneumonia, tuberculosis, chest or breathing complaints or discomfort or any other lung diseases?	☐ Yes ☐ No	☐ Yes ☐ No
e raised cholesterol, high blood pressure, heart attack, heart murmur, prolapsed mitral valve or other heart valve disorders, breathlessness, irregular or fast heart rate, chest discomfort or pain, disease of or any other disorder of the heart or blood vessels?	☐ Yes ☐ No	☐ Yes ☐ No
f gastritis, stomach or duodenal ulcer, blood in stools, fistula, piles or any other stomach or bowel disorders?	☐ Yes ☐ No	☐ Yes ☐ No
g jaundice, being a hepatitis-B carrier or any other form of hepatitis, liver disorder or gall bladder disorder?	☐ Yes ☐ No	☐ Yes ☐ No
h blood, protein or sugar in urine, kidney stones, infection or any other disorders of the kidney, bladder or genital organs?	☐ Yes ☐ No	☐ Yes ☐ No
i slipped disc, gout, arthritis, pain or deformity or disorders of the muscles, spine, limbs or joints or severe injury?	☐ Yes ☐ No	☐ Yes ☐ No
j cancer, tumour, cyst or growth of any kind?	☐ Yes ☐ No	☐ Yes ☐ No
k anaemia, any other disorders of the blood, or had been told not to donate blood or received a blood transfusion or blood products for haemophilia or any other reason?	☐ Yes ☐ No	☐ Yes ☐ No
l any other illness, disorder, operation, physical disability or accident not mentioned above?	☐ Yes ☐ No	☐ Yes ☐ No
2 Have you or your husband or wife received any medical advice, counselling or treatment in connection with sexually transmitted diseases, AIDS, AIDS-related complex or any other AIDS-related conditions?	☐ Yes ☐ No	☐ Yes ☐ No
3 Have you had a HIV test done (please give the reason and results), or in the last three months had any of the following symptoms for more than one week continuously? Feeling tired, weight loss, diarrhoea, enlarged lymph nodes or unusual skin lesions?	☐ Yes ☐ No	☐ Yes ☐ No
4 In the past five years, have you had any test done such as an X-ray, ultrasound, CT scan, biopsy, pap smear, electrocardiogram (ECG), blood or urine test? If you answered yes, please give details of date, type of test, reason for undergoing such test and the test result.	☐ Yes ☐ No	☐ Yes ☐ No
5 Have you had any gain or loss in weight of more than 5kg in the last 12 months? If you answered yes, please give reasons in the space below.	☐ Yes ☐ No	☐ Yes ☐ No
Health questions for females only (age 10 and above)		
6 a Have you had or received any treatment for or plan to be treated for any disease or disorder of the breast including breast lump, breast cyst, fibroadenoma of the breast, fibrocystic disease, nipple changes or discharge, mammary dysplasia, Paget's disease of the nipple or breast, carcinoma in situ of the breast, cancer or growth of the breast?	☐ Yes ☐ No	☐ Yes ☐ No
b Have you had or received any treatment for or plan to be treated for any disease or disorder of the cervix uteri, uterus or ovaries including ovarian cysts, abnormal uterine or vaginal bleeding, uterine fibroids, abnormal enlargement of the abdomen, carcinoma in situ or cancer?	☐ Yes ☐ No	☐ Yes ☐ No
c Have you had an abnormal mammogram, PAP smear, pelvis ultrasound, breast ultrasound, cone biopsy, colposcopy, or other gynaecological test; or have you ever been advised for further follow-up on (or to repeat) any one of these tests within 6 months?	☐ Yes ☐ No	☐ Yes ☐ No
d Have you had any complications during your pregnancy or as a result of your pregnancy (for example, an ectopic pregnancy, diabetes, high blood pressure or protein in the urine)?	☐ Yes ☐ No	☐ Yes ☐ No
e Has any of your children suffered from hereditary disorders (for example, Spina bifida or Down's syndrome)?	☐ Yes ☐ No	☐ Yes ☐ No
f Has any of your children suffered from congenital disorders (for example, club foot, a hole in the heart or cleft lip or palate)?	☐ Yes ☐ No	☐ Yes ☐ No
g Are you now pregnant? If you answered yes, how many weeks?	☐ Yes ☐ No	☐ Yes ☐ No
Health questions for juvenile only (age 15 and below)		
7 a Was the child born before 37 completed weeks of pregnancy?	☐ Yes ☐ No	☐ Yes ☐ No
b Any special care needed after birth?	☐ Yes ☐ No	☐ Yes ☐ No
c Has the child had any physical, congenital or developmental defects or shown any sign of slow physical or mental development?	☐ Yes ☐ No	☐ Yes ☐ No
d Has the child ever had, been told to have, been treated for, been told to get treatment for or suffered symptoms of jaundice?	☐ Yes ☐ No	☐ Yes ☐ No
e Has the child ever had, been told to have, been treated for, been told to get treatment for or suffered symptoms of any condition affecting the sight, hearing or speech?	☐ Yes ☐ No	☐ Yes ☐ No

Questions on health (continued)

If you answered yes to any of the questions above, please give details below.

- The name of the condition and the date of diagnosis.
- The name and address of each doctor and hospital.
- How long the illness or injury lasted and the date of recovery.
- The nature of the tests done, dates, results and reasons for the tests.
- A copy of the above tests, if any.

Please state whether it is for the proposer or insured.

Declaration and authorisation

I will tell you as soon as possible if there is any change in the state of my health or the insured's health or if I or they plan to get any medical consultation, investigation or treatment between the date of this application and before the date you issue this policy. You may add special terms to the policy according to the information provided.

The answers in this application are true, correct and complete. I accept full responsibility for them, whether written by me or by anyone else on my behalf. I have not withheld any information. I agree that this application and other written answers, statements, information or declarations made by me or on my behalf will form the basis of the contract of insurance between me and you. If anything is untrue, incorrect or incomplete, the insurance policy will not be valid.

I confirm that I understand and agree to the 'Personal data collection statement'.

I agree that your legal responsibility will only begin when you accept this application and I have paid the first premium. I agree and authorise:

a any medical source, insurance office or organisation to release to you; and

b you to release to any medical source or insurance office;
any relevant information to do with me or the insured whether you accept my application or not. A photocopy is valid as an original copy.

I understand that it is usually not a good idea to replace an existing investment product (for example, a unit trust) with a new investment product, whether from the same or a different financial institution.

I have been given the following documents and had them explained clearly to me.

a Your Guide to Life Insurance or Your Guide to Health Insurance (or both) b Product Summary c Benefit Illustration

I confirm that the entire marketing and selling process for my proposed insurance application has been carried out in Singapore.

I agree that the policy will be entered in the Register of the Singapore policies.

I am not an undischarged bankrupt and no bankruptcy application (including any statutory order) or order has been made against me.

I also want to apply for membership of Income and if accepted, I agree to keep to your by-laws.

I agree that if I do not reveal any significant fact (which would have affected your decision to accept my application on standard terms) in this application, any policy issued may not be valid. This includes any fact I may not be sure is significant, and also any information I have given to the adviser but was not included in the application.

Signature of proposer, parent or legal guardian Signed in Singapore on (dd/mm/yyyy):	Signature of witness Signed in Singapore on (dd/mm/yyyy):
Signature of insured (for age 16 and above) Signed in Singapore on (dd/mm/yyyy):	Name and NRIC number of witness