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Product Type
☐ Affinity ☐ IncomeShield
☐ Employee Benefit ☐ Life Insurance
☐ LTC

Injury Questionnaire

WARNING: Under Section 25(5) of the Insurance Act, Cap. 142 (or any other future amendments to it), you must reveal all facts you know, or ought to know, which may affect the insurance cover you are applying for. Otherwise, the insurance policy may not be valid.

Please complete ONE questionnaire for each injury declared.

Details of insured

Full name (as in NRIC/BC/Passport/Long-Term Pass)	NRIC/BC/Passport number/FIN	Proposal number(s)

Questions for insured

1. **Description**

a. What injuries did you sustain, on which parts of body and how did you sustain the injuries?

Diagnosis or description of injuries sustained	
Which part(s) of the body (left or right or both) was affected?	
Date (dd/mm/yyyy) and nature of accident	

b. Was there head injury?
☐ Yes (please answer questions below) ☐ No

i. Did you lose consciousness?
☐ Yes, for _____ minutes / hours / days (circle one only) ☐ No

ii. Was there any bleeding in the brain?
☐ Yes (please provide details below) ☐ No

Details

c. Please describe the symptoms or disabilities that you are now having, if any, as a result of the injury (for example, pain, limp, numbness, etc):

Description of symptoms or disabilities	
Date of first occurrence	
Date of last occurrence	

i. What is the nature of the symptom or disability (tick one only)?
☐ Acute i.e. one-off ☐ Chronic i.e. persisting over a long period of time ☐ Recurrent (indicate frequency below)

ii. Frequency:
☐ At least 4 times a year ☐ At least 2 times a year ☐ Once a year ☐ Less often than once a year
☐ Others _____

d. Has any investigation (for example, x-ray, blood test, ECG, etc) been done?
☐ Yes (please provide details below) ☐ No

Type of tests	Results	Date of tests

Details of insured

Full name (as in NRIC/BC/Passport/Long-Term Pass)	NRIC/BC/Passport number/FIN	Proposal number(s)

Questions for insured (continued)

2. **Treatment**

a. Have you seen a doctor for this injury?

☐ Yes (please provide details below) ☐ No

Name and address of doctor	Date of first consultation	Date of last consultation	Result of last consultation

b. Have you ever been hospitalised for this injury?

☐ Yes (please provide details below) ☐ No

Date	Duration of stay	Treatment	Name of hospital

c. i. Have you ever had any surgery done for this injury or is there any intention to do so in the future?

☐ Yes (please provide details below) ☐ No

Date	Nature of procedure	Name of hospital

ii. Was any implant of metal pieces, screws or plates inserted during any of the surgeries?

☐ Yes (please provide details below) ☐ No

Date of implant	Part of the body where the implant was inserted into	Is it still there?	Date of implant removal (if applicable)
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

d. Was there any medication, therapy or other treatment prescribed for this injury?

☐ Yes (please provide details below) ☐ No

Name or description	Dosage	Date or period

Details of insured

Full name (as in NRIC/BC/Passport/Long-Term Pass)	NRIC/BC/Passport number/FIN	Proposal number(s)

Questions for insured (continued)

3. **Current Status**
Please tick the ones that are applicable and provide the required details.

☐ Have fully recovered on _____ (dd/mm/yyyy)
(i.e. no recurrence, no symptom, no complication and no resulting disability or restriction in activities)

☐ Have been fully discharged from medical follow-up on _____ (dd/mm/yyyy)

☐ Still on regular treatment or medical follow-up with doctor or therapist

Frequency	
Date of last consultation	
Date of next consultation	
Name and address of doctor	

☐ Waiting for further investigation or waiting for treatment or surgery

Planned date	
Description	
Name and address of doctor	

☐ Others (please provide details below)

Details

4. **Medical Report**
Please submit a copy of inpatient discharge summary or investigation or medical report(s).
☐ Attached ☐ Not available

Declaration by the proposer and insured

I cannot alter any of the wordings in this form. Any attempt to do so will have no effect.

I declare that the answers given in this form 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. If it is discovered later that I or the Insured suffer from a medical condition that is not disclosed in this form, I will not be entitled to rely on the defence that the information was disclosed for or in the records of other policies with Income. I agree that this form and other written answers, statements, information or declarations I have made or which have been made on my behalf will form the basis of the contract of insurance between the policyholder and Income. If anything is untrue, incorrect or incomplete, the insurance policy will not be valid.

I confirm that there has been no change in my health or the Insured's health since the completion of the application and all additional declarations made in connection with the application. I will notify Income immediately if there is any change in the state of my health or the Insured's health, or if I or the Insured plan to seek medical consultation, investigation, or treatment between the date of this application and the date this policy is in force. I am aware that Income may add special terms to the policy or declare the policy as void according to the information provided or if I fail to notify Income of any change in the state of my health or the Insured's health.

I acknowledge and agree that this form will constitute part of my application for life or health insurance, and will form the basis of the contract of insurance.

I confirm that I understand and agree to the 'Personal Data Use Statement' and declaration set out in my policy application form which I have submitted to Income. I understand that I can refer to Income's Privacy Policy for more information, including access and correction of my personal data and consent withdrawal.

I agree that if I do not reveal any significant fact (which would have affected Income's decision to accept my application on standard terms), any policy issued may be invalid. This includes any facts I may not be sure is significant, and any information I have given to my advisor but was not included in this form.

Signature of proposer	Signature of insured (for age 16 and above)
Date (dd/mm/yyyy):	Date (dd/mm/yyyy):