

Additional Medical Questionnaire

WARNING: Under Section 23(5) of the Insurance Act 1966 (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.

Details of insured

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

1. Have you ever been tested positive or hospitalised for COVID-19?
- No
- Yes, tested positive for COVID-19 more than 1 month ago and not hospitalised (please proceed to Question 2 & 3)
- Yes, tested positive for COVID-19 less than 1 month ago and not hospitalised
- Please state the date you tested positive _____ (dd/mm/yyyy) (please proceed to Question 2 & 3)
- Yes, tested positive for COVID-19 and hospitalised (please proceed to Question 2, 3 & 4)

For applicants with history of COVID-19 infection ONLY

2. a. Do you have any of the following symptoms during or after the infection, other than fever, cough, sore throat, running nose, or loss of taste/smell?
- Please select all that apply.
- Chest pain or tightness
- Shortness of breath
- Dizziness
- Heart palpitations
- Chronic fatigue
- Others, please specify the symptoms: _____
- None of the above (please proceed to Question 3)
- Please state the date of last symptoms (if applicable) _____ (dd/mm/yyyy)

- b. Have you had or are you undergoing or awaiting referral, investigation for above condition(s)?
- Investigation done
- Awaiting referral or investigation
- Advised for investigation but do not plan to do so
- I have not been advised for further investigation

Please provide details below.

Date of tests	Type of tests	Results	Name of doctor	Name of hospital

3. Have you fully recovered, discharged from follow up and/or returned to normal physical function and activities?
- Yes
- No. Please provide details: _____

4. Hospitalisation information

Please select the applicable option:

***HDU:** High-dependency unit, **ICU:** Intensive care unit

- Admitted to General ward only without any need of mechanical ventilation
- Admitted to HDU, ICU, or equivalent ward without any need of mechanical ventilation
- Admitted to HDU, ICU, or equivalent ward with need of mechanical ventilation

Date of admission	Duration of stay	Name of hospital

Details of insured

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