

Details of insured

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

Questions for insured (continued)

4. Have you had or been advised to have any treatment for this condition?

- Yes (please provide details below)
 No

Name or description	Dosage	Date or period

5. Have you ever been hospitalised?

- Yes (please provide details below)
 No

Please enclose a copy of inpatient discharge or clinical summaries.
 Enclosed
 Not available

Date	Duration of stay	Reason or diagnosis	Name of hospital

6. a. Please provide name of your doctor.

b. Please provide name of the clinic or hospital.

7. What is the current status of your condition?

- Have fully recovered and discharged from medical follow-up on _____ (dd/mm/yyyy)
 (i.e. no recurrence, no symptom, no complication and no resulting disability or restriction in activities)
- Currently still on follow-up or monitoring.
 Frequency of follow-up: _____ When was your last follow-up? _____ (dd/mm/yyyy)
- No follow-up required.
- Any other information you wish to share with us.

8. Medical Report

Please submit all medical reports available including inpatient discharge summary, doctor's report, investigation report, histology report, etc.

- Attached
 Not available

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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):