* P R 0 P F *

AVIVA

Health Declaration Form for Underwriting Riders

WARNING: PURSUANT TO SECTION 25(5) OF THE INSURANCE ACT (CAP.142), YOU ARE TO DISCLOSE IN THIS APPLICATION FORM FULLY AND FAITHFULLY ALL FACTS WHICH YOU KNOW OR OUGHT TO KNOW, OTHERWISE THE INSURANCE EFFECTED MAY BE VOID.

This policy is underwritten by Aviva Ltd and will be entered into the register of Singapore policies. The terms and conditions of this policy shall be governed by and construed in accordance with the laws of Singapore.

Policy Number :

Life Assured/Assured :

Gender / Smoker Status : Age Next Birthday:

Occupation :

Residency / Nationality :

SUPPLEMENTARY BENEFITS

Name : Term : Sum Assured / Benefit :

HEALTH QUESTIONS

		Life Assured/Assured
1.	What is your height and weight? If pregnant, please provide weight immediately before pregnancy.	Height : ☐ m Weight : ☐ kg
2.	Is there any weight loss in the last 12 months? (Other than intentional weight loss due to diet control and/or exercise) If '**Yes**', please provide details if you are currently awaiting consultation, hospital referral, tests or investigations. Date of referral Full name of doctor Name of clinic/hospital	☐ Yes ☐ No
3.	Are you a smoker? (including social smokers, cigar smokers or those who have given up within the last 12 months) If '**Yes**', how many sticks do you smoke?	☐ Yes ☐ No ☐ sticks per day
4.	Do you drink alcohol? If '**Yes**', what is the average total number of standard alcoholic drinks do you drink per week? (1 standard alcoholic drink equates 330ml beer, 125ml glass of wine or 30ml nip of spirits)	☐ Yes ☐ No Average total per week ☐
5.	Have you ever been advised by a health care professional or a counsellor to reduce your alcohol use, see a specialist or attend a support group because of your alcohol use? (Excluding advice given whilst pregnant where your alcohol levels were moderate)	☐ Yes ☐ No

HEALTH QUESTIONS *(continued)*

6.	In the last 10 years have you taken or used addictive or illegal drugs (such as cocaine, ecstasy, heroin or cannabis) or been treated for drug addiction?	☐ Yes ☐ No
7.	Have you **ever** had, experienced **symptoms** or received **medical advice** or had **treatment** for any of the following conditions (**whether diagnosed or not**)?	
(a)	Heart attack, chest pain or discomfort, irregular heartbeat, heart valve disorder, heart murmur, cardiomyopathy, palpitations or any other disease or disorder of the heart?	☐ Yes ☐ No
(b)	Stroke, minor stroke, Transient Ischaemic Attack (TIA), brain haemorrhage, brain aneurysm or brain damage?	☐ Yes ☐ No
(c)	Kawasaki disease or any other disease or disorder of the arteries or blood vessels?	☐ Yes ☐ No
(d)	Diabetes, elevated or raised blood sugar or sugar in the urine (including gestational diabetes)?	☐ Yes ☐ No
(e)	Cancer, tumour of any kind including cancer screening tests that were not normal or any cyst of the brain or spine?	☐ Yes ☐ No
(f)	Epilepsy, fits, paralysis or weakness of limb, or any other neurological disease or disorder such as Parkinson's or Motor Neurone Disease?	☐ Yes ☐ No
(g)	Depression, anxiety, stress or any other mental or nervous illness?	☐ Yes ☐ No
(h)	Hepatitis B or C, or abnormal or elevated liver function?	☐ Yes ☐ No
(i)	Sexually transmitted diseases, HIV, AIDS, AIDS related complex or any other AIDS related condition?	☐ Yes ☐ No

If you have answered **'Yes'** to any one of questions 7(a) to 7(i), please complete the following:

Name of **Condition**	Date of **first** symptoms or diagnosis	Have you made a **full recovery** with no further treatment, ongoing symptoms or complications?		Name and address of **doctor** who you consulted
Question ( ) Condition:	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more	☐ **Yes** How long since your **full recovery**? ☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more	☐ **No** What **treatment** or **medication** did you take?	Name: Address:
Name of **Condition**	Date of **first** symptoms or diagnosis	Have you made a **full recovery** with no further treatment, ongoing symptoms or complications?		Name and address of **doctor** who you consulted
Question ( ) Condition:	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more	☐ **Yes** How long since your **full recovery**? ☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more	☐ **No** What **treatment** or **medication** did you take?	Name: Address:

HEALTH QUESTIONS *(continued)*

Name of **Condition**	Date of **first** symptoms or diagnosis	Have you made a **full recovery** with no further treatment, ongoing symptoms or complications?		Name and address of **doctor** who you consulted
Question ( ) Condition:	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more	☐ **Yes** How long since your **full recovery**? ☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more	☐ **No** What **treatment** or **medication** did you take?	Name: Address:
Name of **Condition**	Date of **first** symptoms or diagnosis	Have you made a **full recovery** with no further treatment, ongoing symptoms or complications?		Name and address of **doctor** who you consulted
Question ( ) Condition:	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more	☐ **Yes** How long since your **full recovery**? ☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more	☐ **No** What **treatment** or **medication** did you take?	Name: Address:

8.	In the last 5 years, have you had or experienced symptoms or received medical advice or had treatment for any of the following conditions (whether diagnosed or not):	
(a)	High blood pressure or high cholesterol (other than fully resolved pregnancy related blood pressure)?	☐ Yes ☐ No
(b)	Asthma, bronchitis, pneumonia, tuberculosis, emphysema or any other breathing or lung disorder?	☐ Yes ☐ No
(c)	A lump, growth, polyp, cyst or tumour of any kind or a mole or freckle that has bled, itched, become painful, changed colour or increased in size regardless of whether or not you have consulted a doctor?	☐ Yes ☐ No
(d)	Arthritis, rheumatoid arthritis, gout, or any other disorder, pain or injury to the muscles, joints, tendons or limbs including the neck, back and shoulders?	☐ Yes ☐ No
(e)	Any problems with your ears or eyes (excluding sight problems corrected by prescription lenses)?	☐ Yes ☐ No

If you have answered '**Yes**' to any one of questions 8(a) to 8(e), please complete the following:

Name of **Condition**	Date of **first** symptoms or diagnosis	Have you made a **full recovery** with no further treatment, ongoing symptoms or complications?		Name and address of **doctor** who you consulted
Question ( ) Condition:	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more	☐ **Yes** How long since your **full recovery**? ☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more	☐ **No** What **treatment** or **medication** did you take?	Name: Address:

HEALTH QUESTIONS *(continued)*

Name of **Condition**	Date of **first** symptoms or diagnosis	Have you made a **full recovery** with no further treatment, ongoing symptoms or complications?		Name and address of **doctor** who you consulted
Question ( ) Condition:	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more	☐ **Yes** How long since your **full recovery**? ☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more	☐ **No** What **treatment** or **medication** did you take?	Name: Address:
Name of **Condition**	Date of **first** symptoms or diagnosis	Have you made a **full recovery** with no further treatment, ongoing symptoms or complications?		Name and address of **doctor** who you consulted
Question ( ) Condition:	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more	☐ **Yes** How long since your **full recovery**? ☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more	☐ **No** What **treatment** or **medication** did you take?	Name: Address:

9.	Other than the conditions that you have already told us about, within the last 5 years have you:	
(a)	Had any abnormal medical test results such as x-ray, ultrasound, imaging scan, biopsy, electrocardiogram (ECG), blood or urine test, prostate check, pap smear or mammogram ? If '**Yes**', please complete the following:	☐ Yes ☐ No

Name of medical test	Date of initial test	Have you had a follow-up test ?	Date of follow-up test	Have you been prescribed treatment or been advised to have any further test?	Name and address of **doctor** who you consulted
	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years	☐ Yes ☐ No If '**Yes**', what was the result? ☐ normal ☐ abnormal ☐ don't know	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years	☐ Yes ☐ No If '**Yes**', please provide details	Name: Address:
	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years	☐ Yes ☐ No If '**Yes**', what was the result? ☐ normal ☐ abnormal ☐ don't know	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years	☐ Yes ☐ No If '**Yes**', please provide details	Name: Address:

HEALTH QUESTIONS *(continued)*

(b)	Had any medication or treatment that lasted more than 4 weeks?	☐ Yes ☐ No
(c)	Been referred to, treated at or had any investigations at a hospital or clinic?	☐ Yes ☐ No
(d)	Been absent from work or unable to perform your daily activities due to illness, disorder or injury for more than two weeks at a time?	☐ Yes ☐ No

If you have answered '**Yes**' to any one of questions 9(b) to 9(d), please complete the following:

Exact Diagnosis	Date of **first** symptoms or diagnosis	Have you made a **full recovery** with no further treatment, ongoing symptoms or complications?		Details of Investigations (type of tests, dates and results)	Name and address of **doctor** who you consulted
	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more	☐ Yes How long since your **full recovery**? ☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more	☐ No What **treatment** or **medication** did you take?		Name: Address:
Exact Diagnosis	Date of **first** symptoms or diagnosis	Have you made a **full recovery** with no further treatment, ongoing symptoms or complications?		Details of Investigations (type of tests, dates and results)	Name and address of **doctor** who you consulted
	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more	☐ Yes How long since your **full recovery**? ☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more	☐ No What **treatment** or **medication** did you take?		Name: Address:

HEALTH QUESTIONS *(continued)*

10.	Other than any conditions, scans, tests or investigations you have already told us about, are you currently:	
(a)	Waiting for the results of any tests or investigations? Please provide type of tests, date and reason as well as the name of the doctor/clinic consulted.	☐ Yes ☐ No
(b)	Experiencing symptoms or a condition that you're likely to seek medical advice or treatment for? If **'Yes'**, please provide details including nature of symptoms, severity and frequency of symptoms.	☐ Yes ☐ No
(c)	Do you currently have any physical or mental condition that restricts or causes difficulty in performing your daily activities (such as housework, preparing meals, shopping, using public transport, a hobby been reduced or restricted in anyway due to your health or your occupation)? If **'Yes'**, please complete the following:	☐ Yes ☐ No

Exact Diagnosis	Date of onset	Details of Investigations (type of tests, dates and results)	Details of treatment	Name and address of **doctor** who you consulted
	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years			Name: Address:

Exact Diagnosis	Date of onset	Details of Investigations (type of tests, dates and results)	Details of treatment	Name and address of **doctor** who you consulted
	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years			Name: Address:

HEALTH QUESTIONS *(continued)*

11.	Have any of your natural parents or siblings been diagnosed with or died from any of the following before the age of 60: Alzheimer's disease, bowel or colon cancer, breast or ovarian cancer, cardiomyopathy, coronary artery disease, diabetes, heart attack, heart failure, huntington's disease, ischaemic heart disease, motor neurone disease, multiple sclerosis, muscular dystrophy, parkinson's disease, polycystic kidney disease, stroke or any other hereditary disease or disorder? If **'Yes'**, please complete the following:	☐ Yes ☐ No

Name of medical condition (**specific exact condition** e.g. if cancer, specify which type, if heart disease, name the condition)	Family member's relationship to you	Age when diagnosed	Age at death (if applicable)

12.	Has your spouse or partner been told to have, received any medical advice, counselling or treatment in connection with sexually transmitted diseases, HIV, AIDS, AIDS related complex or any other AIDS related condition? If **'Yes'**, please provide details.	☐ Yes ☐ No

DECLARATION

Important Notes:
If a material fact is not disclosed in this application, any policy issued may not be valid. If you are in doubt as to whether a fact is material, you are advised to disclose it. This includes any information that you may have provided to the Financial Adviser Representative but was not included in the application. Please check to ensure you are fully satisfied with the information declared in this application.

Signature of Life Assured : _____

Date : _____

Name : _____

Identity Card / Passport No. : _____

Signature of Witness / Financial Adviser Representative : _____

Date : _____

Name : _____

Identity Card / Passport No. : _____

Signature of Proposer (Assured) / Joint Life Assured : _____

Date : _____

Name : _____

Identity Card / Passport No. : _____