



* Q U E S T *



Thyroid Disorder Supplementary Questionnaire (Q37)

Particulars of Life Assured

Name : _____

Identity Card / Passport No. : _____ Contract No. : _____

Medical Questions

1. Please state the diagnosis made by the doctor (eg Hyperthyroidism / Hypothyroidism / Thyroid Nodule).

2. When was this condition diagnosed?

3. Please describe your symptoms.

4. Have you undergone any investigations (eg ultrasound, blood test)?

Yes No

If 'Yes', please provide details:

Type of Investigation / Test	Date	Results*	
		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal

* For abnormal results, please provide details: _____

5. What treatment was or has been prescribed by your doctor?

Please tick accordingly and provide details:

Oral Medication

Name of Medication	Dosage	Frequency	Start Date of Medication	End Date of Medication (if applicable)

Others, please provide details: _____

Please specify date of last treatment (if applicable): _____

6. Please indicate your latest thyroid function test results and attach a copy of the results.

Date of Test	Free T4	Thyroid Stimulating Hormone (TSH)

7. Have you had a surgery for this condition or is a surgery being considered / planned?

Yes No

If 'Yes', please provide details:

Date of Surgery	Nature of Surgery	Results

8. Was there any recurrence of symptoms?

Yes No

If 'Yes', please provide details:

9. Was there any other disease or associated disorders (eg hypertension, heart disorder)?

Yes No

If 'Yes', please provide details:

10. Have you taken time off work or school due to this condition?

Yes No

If 'Yes', please provide details:

Date	Duration of Time-off

11. Please provide the name and address of the doctor / clinic / hospital which you have consulted for this condition.

Name of Doctor / Clinic / Hospital	Address	Date of Last Consultation

Note: Please provide us with copies of all medical reports relating to this condition, if available.

Declaration

I/We agree to inform Aviva Ltd if there is any change in my/our health status between the date of this Declaration and the date full insurance coverage is provided by Aviva Ltd to me/us. I/We understand that the terms of accepting me/us as a risk for insurance coverage may vary according to such information received.

I/We agree that the above information shall form the basis of my/our application for insurance. I/We declare that the information given is true and complete and I/we have not withheld any material information that may influence the assessment of my/our application.

Name and Signature of Life Assured

Date (dd/mm/yyyy)

Name and Signature of Assured

Date (dd/mm/yyyy)