Mental Health Supplementary Questionnaire (Q40)

Particulars of Life Assured

Name : _____

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

Medical Questions

1. What was the diagnosis made by the doctor?

_____

2. When was this condition diagnosed?

_____

3. Please provide details of your symptoms:

Symptoms	Number of Attacks Since First Occurrence	Start Date of Symptoms	Duration of Symptoms

4. What were the triggering factors or situation which triggers or exacerbates your symptoms or condition?

_____

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): _____

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6. Have you ever received psychotherapeutic therapy?

☐ Yes ☐ No

If '**Yes**', please provide details: _____

7. Have you ever received electroconvulsive therapy (ECT)?

☐ Yes ☐ No

If '**Yes**', please provide details: _____

8. Have you ever had treatment as a hospital out-patient or seen a psychiatrist?

☐ Yes ☐ No

If '**Yes**', please provide details:

Name of Institution/Doctor	Type of Treatment Received	Date of Treatment

9. Have you ever been an in-patient at a hospital?

☐ Yes ☐ No

If '**Yes**', please provide details:

Date of Admission	Name of Doctor / Psychiatrist	Name of Hospital	Period of Hospitalisation

10. Have you ever had any suicidal ideas, tendencies or actual suicide attempts?

☐ Yes ☐ No

If '**Yes**', please provide details:

Date of Occurrence	Follow-up Treatment

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

☐ Yes ☐ No

If '**Yes**', please provide details:

Date	Duration of Time-off

12. 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)

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