Digestive Disorder Supplementary Questionnaire (QA9)

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 describe your symptoms: _____

   (a) Date of first occurrence of symptoms: _____

   (b) Number of attack(s) per year: _____

   (c) Date of last occurrence of symptoms: _____

4. Do you have any episode of bleeding?

   ☐ Yes ☐ No

   If '**Yes**', how many times since onset and the dates of occurrence: _____

5. Are your symptoms related to any particular factor (eg stress, alcohol, diet)?

   ☐ Yes ☐ No

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

   _____

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6. Have you undergone any investigations (eg gastroscopy, colonoscopy, barium meal)?

☐ Yes ☐ No

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

Type of Investigation / Test	Date	Results*
		☐ Normal ☐ Abnormal
		☐ Normal ☐ Abnormal
		☐ Normal ☐ Abnormal
		☐ Normal ☐ Abnormal
		☐ Normal ☐ Abnormal

* For abnormal results, please provide details: _____

_____

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. 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)

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☐ **Regular Surveillance** (eg ultrasound / scan / scope)

Type of Test	Date of Last Test	Results	Date of Next Test

☐ **Others**, please provide details: _____

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

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

☐ Yes ☐ No

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

Date	Duration of Time-off

10. 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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