Aviva Ltd
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Company Reg No.: 196900499K GST Reg No.: MR-8500166-8

AVIVA

Group Life & Health Underwriting

Policy No. ☐☐☐☐☐☐☐☐

MEDICAL EXAMINATION FORM (PART I) - PERSONAL STATEMENT BY THE EXAMINEE

IMPORTANT NOTE: Pursuant to Section 25(5) of the Insurance Act (Cap. 142), you are to disclose in this form, fully and faithfully, all the facts which you know or ought to know, otherwise, nothing may be payable under the Policy.

A. PARTICULARS OF EXAMINEE (Please complete in capital letters)

Full Name as shown on NRIC/Passport/BC (Underline Surname)
*Mr/Mrs/Mdm/Miss/Dr

Email Address: _____

Residential Address

Postal Code

Country of Residence: _____

*NRIC/Passport/BC No.

Date of Birth
D D M M Y Y Y Y

Age Next Birthday

Gender: ☐ Male ☐ Female

Nationality: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Dicorced

Occupation and Exact Nature of Duties

Name and Address of Company

Tel No.
(H)
(O)
EXT

* Please delete accordingly

B. PLEASE ANSWER THE FOLLOWING QUESTIONS (To be answered by the Examinee)

1a. Do you have a regular doctor? Yes ☐ No ☐
If Yes, please state the name and address of your regular doctor.

1b. Please state the type of illness consulted, date of consultations and the result of such consultations with your regular doctor.

	Yes	No	If "Yes", please give details such as date of onset/test, names & address of doctor, results of investigation, type of treatment, any recurrence/fully recovered.
2. Are you now receiving, considering receiving medical treatment from a doctor or any intention to consult any doctor for any reason, seek further treatment or alternative medicine?	☐	☐	
3. Have you ever undergone any special investigation such as X-ray, ultrasound, electrocardiogram, mammogram, blood or urine test etc. in the past 5 years? (Please state date, reason, type and result of tests done.)	☐	☐	
4. Have you ever had, or been told to have or been treated for:-	Yes	No	If "Yes", please give details such as date of occurrence, investigation / treatment provided and name / address doctor.
a. epilepsy / fits, stroke, paralysis / weakness of limb, prolonged headache, nervous breakdown, depression or any other nervous / mental disorders?	☐	☐	
b. cataract, ear infection / discharge or any other disorders of eye, ear, nose or throat?	☐	☐	
c. asthma, bronchitis, persistent cough, coughing with blood pneumonia, tuberculosis, breathing complaints/discomfort or any other lung disorders?	☐	☐	
d. raised cholesterol, high blood pressure, heart attack, mitral valve prolapse or other heart valve disorders, breathlessness, fast heart rate, chest pain, or any disease or disorders of the heart?	☐	☐	

	Yes	No	If "Yes", please give details such as date of occurrence, investigation / treatment provided and name / address doctor.
e. diabetes mellitus, thyroid disorder or any endocrine disease?	☐	☐	
f. gastritis, stomach or duodenal ulcer, blood in stools, fistula, piles or any other stomach or bowel disorder?	☐	☐	
g. jaundice, hepatitis B carrier or any form of hepatitis, liver or gallbladder disorder?	☐	☐	
h. blood, protein or sugar in urine, kidney stones, infection or any other disorders of the kidney, bladder or genital organs?	☐	☐	
i. cancer, tumour, cyst or growth of any kind?	☐	☐	
j. slipped disc, backache, gout, arthritis, pain or deformity or disorders of the muscles, spines, limbs or joints or severe injury?	☐	☐	
k. any sexually transmitted disease, eg syphilis, gonorrhoea, non-specific urethritis, herpes, HIV infection or AIDS?	☐	☐	
l. endometriosis, fibroids, cysts, breast lumps, abnormal pap smear, irregular or painful menstruation or any other disorders of the female organs?	☐	☐	
m. anaemia, haemophilia or any disorders of the blood?	☐	☐	
n. any other illnesses, congenital or hereditary disorders, any hospitalisation or physical injuries not listed above?	☐	☐	
5. Have you ever received any blood transfusion or ever been refused as a blood donor?	☐	☐	
6. Have you smoked in the past 12 months? If "Yes", please state numbers of years and the number of sticks per day.	☐	☐	No of Years _____ No of Sticks/day _____
7. Do you consume alcohol? If "Yes", please state the quantity, type and frequency.	☐	☐	Quantity _____ Type _____ Frequency _____
8. Do you engage in hazardous activity such as aviation (other than as a private paying passenger), scuba/skin diving, motor racing, mountaineering, etc?	☐	☐	
9. Do you engage in activities that will increase exposure to AIDS or AIDS related conditions?	☐	☐	
10. Have any of your natural parents or siblings died or suffered from (a) heart disease (b) high blood pressure (c) stroke (d) diabetes (e) cancer (f) kidney disease (g) mental disorder (h) muscular disorder or any other hereditary disease?	☐	☐	

Relationship	Condition/cause of Death	Age at offset	If Deceased, Age at Death

C. PERSONAL DATA CONSENT(S)

On Behalf of myself and dependants, I/we consent to Aviva (and Aviva related group of companies) collecting, using and/ or disclosing my/our personal data to issue and administer my existing and/or new policies or insurance coverage(s) with Aviva

On Behalf of myself and my dependants. I/we also consent to Aviva (and Aviva related group of companies) transferring my/our personal data to Aviva related group of companies and/or third party service providers, reinsurers, suppliers or intermediaries, whether located in Singapore or elsewhere, for the above purposes.

For full details of the purposes of collection, use and disclosure of you personal data, please Visit **http://www/aviva.com.sg/pdpa.html**

D. DECLARATION

I declare that the answers were given by me in reply to the questions put to me and to the best of my knowledge and belief, the information furnished herein are true and complete and I agree that they are in continuation of and form part of my proposal and that failure to disclose any material known fact to me may invalidate the Policy. I agree to inform Aviva Ltd if there is any change in the state of my health or my activities between the date of this Health Declaration/Medical Examination and the date full insurance coverage is provided by Aviva Ltd to me. I understand that the terms of accepting me as a risk for insurance coverage may vary according to such information received. I authorise any medical source, insurance office or organisation to release to Aviva Ltd and similarly Aviva Ltd to release to any of the prior mentioned organisations, relevant information concerning me at any time, irrespective of whether the proposal is accepted by Aviva Ltd. A photographic copy of this authorization shall be as valid as the original.

Only applicable to Group Medical products (including Livingcare & Disability Income) for all voluntary and flexible benefits.
I/We confirm that I/We have received a copy of Your Guide to Health Insurance and Product Summary and have read and understood the contents of these two documents.

_____
Signature of Examinee

Date _____

_____
Signature of Medical Examiner

Date _____

MEDICAL EXAMINATION FORM (PART II) - MEDICAL EXAMINER'S CONFIDENTIAL REPORT

This examination should be in private, without the presence of a third party except as chaperon or interpreter. The medical examiner is requested to send this report in a sealed envelope as it is strictly confidential between the Company and the examiner. Please note that we may be obliged to disclose results of the medical examination to the examinee at his request.

A. PLEASE ANSWER THE FOLLOWING QUESTIONS (To be answered by the Medical Examiner)

	Yes	No	Please give full details of any abnormality
1. Are you personally acquainted with the examinee? If so, in what capacity and please provide details of any consultations?	☐	☐	
2. **CNS, SKELETAL SYSTEM** a) Are there any diseases of the central or peripheral nervous system? b) Are the tendon reflexes **abnormal**? c) Any paralysis or tremors? d) Any bones or joints deformity, amputation?	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	
3. **CHEST** a) Are the shape, capacity & expansion of the chest **unsatisfactory**? b) Are the breath sounds **abnormal**? If not, please describe the adventitious sounds heard.	☐ ☐	☐ ☐	
4. **HEART** a) Is the Apex beat **abnormal**? b) Are there any signs of hypertrophy or dilatation? c) Are there any **abnormalities** in the heart sounds? d) Are there any murmurs? If Yes, please indicated the grade of murmurs. e) Blood pressure - (if SBP>140, or DBP>90 (5th phase), please take 2 further readings with interval of 5 minutes. If the examinee is hypertensive, please state, if known, the readings with relevant dates.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	**PULSE RATE** beats/minutes _____ ***Regular / Irregular** **BLOOD PRESSURE** | 1 | 2 | 3 Systolic(mm Hg) Diastolic(mm Hg) 5th phase
5. **ABDOMEN** a) Are the **liver, spleen, kidneys** palpable? b) Are there any **abnormal abdominal mass**, such as hernia, tumour? c) Are there any symptoms of any digestive disturbances?	☐ ☐ ☐	☐ ☐ ☐	
6. Are there any diseases of the **thyroid** or **endocrine glands**?	☐	☐	
7. Are there any **Ear**, **Nose** or **Throat** abnormality?	☐	☐	
8. Are there any diseases of the **Eyes**? Are there any arcus senilis, xanthoma or any stigma of vascular abnormality?	☐	☐	**VISUAL ACUITY * Aided / Unaided** | Right | Left Distant Near

	Yes	No	Please give full details of any abnormality
9. a) **GENITOURINARY SYSTEM** Are there any diseases of the urinary and genital organs? eg. varicocele, calculus.	☐	☐	Female examinee: to indicate LMP when blood is present
b) **URINE EXAMINATION** Send specimen for microscopic urinalysis if blood (provided not due to menses) or albumin is present or history of urinary disease. If urine sugar is present, to draw blood for HbAIC and blood sugar (to indicate if its fasting or random)			**URINE EXAMINATION** PH | Albumin | Sugar | Blood | Put cells or other abnormalities
10. a) Does he/she has any visible growth, tumour or enlargement? If so, please state its location and its nature.	☐	☐	
b) Are there any significant changes in his or her appetite, weight and bowel habits recently? If so, please elaborate.	☐	☐	
c) Are you of the opinion that he/she is particularly exposed to the risk of HIV infection?	☐	☐	
d) Are there any further medical or information required to enable a correct judgement of the risk	☐	☐	
11. a) Please furnish his/her height & weight.			Height(m) _____ Weight(kg) _____
b) Has the weight *increased, decreased or remained the same during the pass one year?			☐ Increased ☐ Decreased ☐ Stable
c) Is there any unexplained weight loss? If Yes, please provide reasons for the weight loss.			☐ Yes ☐ No
12. Please furnish his/her chest and abdomen measurements.			a) Inspiration _____ cm
a) & b) Circumference of chest at nipple level			b) Expiration _____ cm
c) Circumference of abdomen at umbilicus			C) Abdomen _____ cm
13. In the case of a **Female**:- a) Are there any lumps or lesions in the breasts?	☐	☐	
b) Are there any obstetrics or gynaecological abnormalities whether past or present? eg. Fibroid, ovarian cyst etc.	☐	☐	
c) Is she now pregnant? If yes, please give the gestational stage. _____	☐	☐	

B. MEDICAL EXAMINER'S REMARKS

Please comment and provide any additional information on the examinee that would assist Aviva's assessment of the application.

C. SIGNATURE

Signature of Medical Examiner _____ Name of Medical Examiner _____

Date of Examination _____ Clinic's Stamp _____

*** Please delete accordingly**

This Report should be sent directly to Group Life & Health Underwriting.