

Important Notice

Statement pursuant to Section 25(5) of the Insurance Act (Cap. 142) (or any subsequent amendments thereof): You are to disclose in this Application Form, fully and faithfully, all the facts which you know or ought to know in respect of the risk that is being proposed. Otherwise, the Policy issued hereunder may be void. Neither this Application Form nor the brochure is a contract of insurance. However, your declarations or disclosures shall form the basis of the contract of insurance. The specific terms, conditions and exclusions applicable to this insurance are set out in the Policy, a copy of which is available upon request.

Insured Person Information

Name of Insured Person: _____

Policy Number: _____

Medical/Health Condition concerned: _____

Date of Birth (dd/mm/yyyy): _____ Gender: M F Height (cm): _____ Weight (kg): _____

1. Regarding your symptoms:

(a) What was the main complaint of the condition? _____

(b) When was the condition first diagnosed? _____

(c) How frequently did the symptoms occur in the last 12 months? Please provide duration. _____

(d) When was the last occurrence of the symptoms? _____

(e) In which part of the body was it situated? _____

2. Have you had any tests or other investigations for this condition? Yes No. If Yes, please provide details, including dates or investigations and results. (Please attach copy of medical report(s) with this questionnaire if available.)

3. Final Diagnosis: _____

4. Treatment (Please tick the appropriate box and specify period of treatment with commencement and completion date)

Oral medication – please provide details of medication: _____

Name & Date of Surgery: _____

Physiotherapy or Chiropractic treatment or Chinese medicine practitioner or others: _____

5. Are you currently receiving any treatment, or currently on long term medication or suffering from a chronic disease? Yes No.

If Yes, please give details of treatment: _____

6. Is regular follow-up required? Yes No. If Yes: _____

Any sign of recurrence? _____

Regular follow up: _____

State your last follow-up date: _____ Next follow-up date: _____

7. Is any planned treatment or surgery required? Yes No. If Yes, please give details of treatment: _____

8. Have you lost any time from work? Yes No. If Yes, please provide duration and dates. _____

9. Name and address of your treating Physician and/or Hospital: _____

10. Have you fully recovered? Yes No

11. Please tell us your blood pressure if known: _____

I hereby declare that all answers to the foregoing questions are correctly recorded, and that they are complete and true.

Signature of the Insured Person
(Signature by Policyholder if the Insured Person is a Minor)

Date