GENERAL MEDICAL QUESTIONNAIRE

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 enrolment form nor the brochure is a contract of insurance. However, your declarations or disclosures shall form the basis of the contract of insurance. The specified terms, conditions and exclusions applicable to this insurance are set out in the policy, a copy of which is available upon request.

Name of Insured: I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I

Policy Number: I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I

Medical/Health Condition concerned: I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I___I

Date of Birth (dd/mm/yy): I___I___I/I___I___I/I___I___I Gender (M/F): I___I Height (cm): I___I___I___I Weight (kg): I___I___I___I

1. Description of signs and symptoms:

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

   (b) When did the condition happen? _____

   (c) Frequency & Duration: _____

   (d) Sites if applicable: _____

   (e) Time or Date of (i) Initial (first) episode: _____

   (ii) Latest occurrence: _____

2. Diagnostic procedure (Please tick the appropriate boxes and attach copy of medical report(s) with this questionnaire, if available)

   ☐ X-ray ☐ Ultrasound ☐ MRI Biopsy ☐ Others – please specify _____

   Findings of the above investigations: _____

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? ☐ 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: _____

   Date of latest follow up: _____ Date of next follow up: _____

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

   _____

8 Loss of time from work (please provide the duration and dates): _____

9. Name and address of current attending doctor and clinic/hospital: _____

   _____

10. Have you fully recovered? ☐ Yes ☐ No

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

_____ _____

Signature of the Insured / Main Applicant
(Signature by Policyholder if the insured person is a Minor)

Date

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