



TUMOUR & CYST QUESTIONNAIRE

Please fill in **ENTIRE FORM** using **BLOCK CAPITALS**

(With reference to Q6A)

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.

Medical/Health Condition concerned: _____

Name of Insured: _____

ID/Passport No.: _____

1. When was the growth, cyst, lump or tumour first discovered? _____

2. In which part of the body was it situated? _____

3. Please state the precise diagnosis if known: _____

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

5. Has the growth been removed? Yes No. If "Yes", please provide:

a) Date of surgery: _____

b) Name of surgeon, general practitioner, consultant, hospital or clinic: _____

c) What treatment have you had following removal? (e.g. tablets, radiotherapy, chemotherapy, etc) and please specify commencement and completion date of treatment: _____

d) Have you been given any information regarding outlook &/or prognosis? Yes No. (If "Yes", please specify): _____

e) Details of investigations which have been carried out, including date(s) and result of tests: _____

f) Details of any proposed treatment or surgery: _____

g) Chinese medicine practitioner or others: _____

6. Regarding the monitoring of your condition:

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

b) If you have been discharged from follow-up, please state when: _____

7. Name and address of current attending Doctor or Hospital: _____

8. Have there been any sign(s) of recurrence or metastasis to other parts of the body? Yes No. If "Yes", please provide full medical report(s) from the attending doctor on the above condition: severity of condition and prognosis; dates and past treatments given; current treatment / medication (if any); planned or upcoming treatment (if any); and current symptoms (if any):

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