SPECIAL HEALTH QUESTIONNAIRE



No. Questions	Policy No.:					
No. Questions Details	Na	ame	of Life to be Assured:			
Name of medical condition: Name of medical condition:			NRIC / Passport No.:			
2 Signs & Symtoms: Please provide full details and state the date of the first signs and symptoms (for example chest pain, giddiness, palpitation). 3 Investigations: Hove you had or are you having investigations done (for example blood test, urine test), ECG CT scan)? If yes, please state the dates, types and results of investigations. 4 Diagnosis: Please state the diagnosis and date of diagnosis. 5 Medications Have you had or are you having reatment or taking medication? If yes, please state all past and present treatment or medication, including name and dosage. 6 Surgery Have you had any surgery done? If yes, please state the dates and types of surgerites. 7 Hospitalisation Have you ever been hospitalised? If yes, please state the name of hospital(s), dates and duration of each hospitalisation. 8 Time.Off.Work Have you been given medical leave or any time off work or school due to medical leave or time off. 9 Current_status 1 Have you fully recovered with no residual effects or complications? 1	\[\begin{array}{c} \be	lo.	Questions Details			
Please provide full details and state the date of the first signs and symptoms (for example chest pain, giddiness, palpitation).	1		Name of medical condition:			
Have you had or are you having investigations done (for example blood test, urine test, ECG, CT scan)? If yes, please state the dates, types and results of investigations. 4 Diagnosis: Please state the diagnosis and date of diagnosis. 5 Medications Have you had or are you having treatment or taking medication? If yes, please state all past and present treatment or medication, including name and dosage. 6 Surgery Have you had any surgery done? If yes, please state the dates and types of surgeries. 7 Hospitalisation Have you ever been hospitalised? If yes, please state the name of hospital(s), dates and duration of each hospitalisation. 8 Time Off Work Have you been given medical leave or any time off work or school due to medical leave or time off. 9 Current status a) Have you fully recovered with no residual effects or complications? b) Please state the date of recovery and discharge from follow-up, or date of next follow-up. If not fully recovered, please state details of residual conditions, complications or restrictions. c) If applicable, how many times did the condition or symptoms occur in the last 12 months? When was the date of last symptoms? attack? d) If applicable, how many times did the condition or symptoms occur in the last 12 months? When was the date of last symptoms? attack? d) If applicable, how many times did the condition or symptoms occur since the start? 10 Doctor Please state the name and address of hospital or doctor who treated / investigated you for this condition. 11 Lagree that the sanswers given are, to the best of my knowledge, true and that failure to disclose any material known fact by me may invalidate this contract of insurance.	2	2	Please provide full details and state the date of the first signs and			
lest, unne test, ECS, CI scan)? If yes, please state the dates, types and results of investigations. Please state the diagnosis and date of diagnosis. Details: Date: Date: Date	3	3				
Diagnosis: Please state the diagnosis and date of diagnosis. Date :			test, urine test, ECG, CT scan)? If yes, please state the dates, types and Type(s):	_		
Medications	4	1	Diagnosis: Details:	_		
Have you had or are you having treatment or taking medication? If yes, please state all past and present treatment or medication, including name and dosage. Yes, but stopped Yes, but stopped Yes, but stopped Yes Dosage : Dosag	-	5	Mediantions	\dashv		
Surgery Have you had any surgery done? If yes, please state the dates and types of surgeries. No Date :			Have you had or are you having treatment or taking medication? If yes, please state all past and present treatment or medication, including name and dosage. Yes, currently Yes, but stopped Name: Dosage:	_		
Have you had any surgery done? If yes, please state the dates and types of surgeries. Date :	-	3	Commons	=		
Hospitalisation			Have you had any surgery done? If yes, please state the dates and types of surgeries.	-		
Have you ever been hospitalised? If yes, please state the name of hospital(s), dates and duration of each hospitalisation. 8	F	7	Hospitalisation	\exists		
Sample Time Off Work Have you been given medical leave or any time off work or school due to this condition? If yes, please state the dates and duration of each medical leave or time off. Duration :			Have you ever been hospitalised? If yes, please state the name of hospital(s), dates and duration of each hospitalisation. Hospital:	-		
Have you been given medical leave or any time off work or school due to this condition? If yes, please state the dates and duration of each medical leave or time off. 9	H	8	Time Off Work	\exists		
Current status Yes			Have you been given medical leave or any time off work or school due to this condition? If yes, please state the dates and duration of each Date:	_		
a) Have you fully recovered with no residual effects or complications? b) Please state the date of recovery and discharge from follow-up, or date of next follow-up. If not fully recovered, please state details of residual conditions, complications or restrictions. c) If applicable, how many times did the condition or symptoms occur in the last 12 months? When was the date of last symptoms/ attack? d) If applicable, how many times did the condition or symptoms occur since the start? No. of times: Date: Name of Hospital/Doctor: Address: I hereby declare that the answers given are, to the best of my knowledge, true and that I have not withheld any material information that may influence the assessment of my proposal. I agree that this form will constitute part of my proposal for life assurance and that failure to disclose any material known fact by me may invalidate this contract of insurance.	r	9	Ourseast atatus			
of next follow-up. If not fully recovered, please state details of residual conditions, complications or restrictions. C) If applicable, how many times did the condition or symptoms occur in the last 12 months? When was the date of last symptoms/ attack? d) If applicable, how many times did the condition or symptoms occur since the start? 10 Doctor Please state the name and address of hospital or doctor who treated / investigated you for this condition. Name of Hospital/Doctor:		-	a) Have you fully recovered with no residual effects or complications?	4		
c) If applicable, how many times did the condition or symptoms occur in the last 12 months? When was the date of last symptoms/ attack? d) If applicable, how many times did the condition or symptoms occur since the start? 10 Doctor Please state the name and address of hospital or doctor who treated / investigated you for this condition. Name of Hospital/Doctor: Address: Address: I hereby declare that the answers given are, to the best of my knowledge, true and that I have not withheld any material information that may influence the assessment of my proposal. I agree that this form will constitute part of my proposal for life assurance and that failure to disclose any material known fact by me may invalidate this contract of insurance.			of next follow-up. If not fully recovered, please state details of residual Date of next follow-up:	_		
d) If applicable, how many times did the condition or symptoms occur since the start? 10 Doctor Please state the name and address of hospital or doctor who treated / investigated you for this condition. Name of Hospital/Doctor: Address: Address: I hereby declare that the answers given are, to the best of my knowledge, true and that I have not withheld any material information that may influence the assessment of my proposal. I agree that this form will constitute part of my proposal for life assurance and that failure to disclose any material known fact by me may invalidate this contract of insurance.			c) If applicable, how many times did the condition or symptoms occur	_		
I hereby declare that the answers given are, to the best of my knowledge, true and that I have not withheld any material information that may influence the assessment of my proposal. I agree that this form will constitute part of my proposal for life assurance and that failure to disclose any material known fact by me may invalidate this contract of insurance.			d) If applicable, how many times did the condition or symptoms occur			
may influence the assessment of my proposal. I agree that this form will constitute part of my proposal for life assurance and that failure to disclose any material known fact by me may invalidate this contract of insurance.		10		_ _		
invalidate this contract of insurance.		I hereby declare that the answers given are, to the best of my knowledge, true and that I have not withheld any material information that may influence the assessment of my proposal.				
Signature of Proposer / Life to be Assured : Date :				зy		
	Si	gna	ture of Proposer / Life to be Assured : Date :	_		

The Great Eastern Life Assurance Company Limited (Reg. No. 1908 00011G)

New Business Underwriting Department

1 Pickering Street, #01-01, Great Eastern Centre, Singapore 048659

For enquiries, call (65) 62482000 or visit us at greateasternlife.com > Contact Us > Proposal follow Up