SPECIAL HEALTH QUESTIONNAIRE

Great Eastern
A member of the OCBC Group

Policy No.: ☐☐☐☐☐☐☐☐☐☐

Name of Life to be Assured: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ NRIC / Passport No.: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

No.	Questions	Details
1	Name of medical condition:	
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: 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.	☐ Yes ☐ No Date : ________ Type(s) : ________ Results : ________
4	Diagnosis: Please state the diagnosis and date of diagnosis.	Details : ________ Date : ________
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.	☐ Yes, currently ☐ No, never ☐ Yes, but stopped Name : ________ Dosage : ________ Date of last medication : ________
6	Surgery Have you had any surgery done? If yes, please state the dates and types of surgeries.	☐ Yes ☐ No Date : ________ Type(s) : ________
7	Hospitalisation Have you ever been hospitalised? If yes, please state the name of hospital(s), dates and duration of each hospitalisation.	☐ Yes ☐ No Hospital : ________ Date : ________ Duration : ________
8	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.	☐ Yes ☐ No Date : ________ Duration : ________
9	Current status a) Have you fully recovered with no residual effects or complications?	☐ Yes ☐ No
	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.	Date of discharge from follow-up: ________ Date of next follow-up: ________ Details : ________
	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?	No. of times : ________ Date : ________
	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 : ________

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.

Signature of Proposer / Life to be Assured : ________________ Date : ________________

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