Income Insurance Limited | UEN: 202135698W
Income Centre 75 Bras Basah Road Singapore 189557
Tel: 6788 1777 · Fax: 6338 1500
Email: csquery@income.com.sg · Website: www.income.com.sg

Product Type
☐ Affinity ☐ IncomeShield
☐ Employee Benefit ☐ Life Insurance
☐ LTC

Medical History Questionnaire

Medical Condition:

WARNING: Under Section 23(5) of the Insurance Act 1966 (or any other future amendments to it), you must reveal all facts you know, or ought to know, which may affect the insurance cover you are applying for. Otherwise, the insurance policy may not be valid.

Details of insured

Full name (as in NRIC/BC/Passport/Long-Term Pass)	NRIC/BC/Passport number/FIN	Proposal number(s)

Questions for insured

1. Description
   a. Please state the date of diagnosis.

   _____ (dd/mm/yyyy)

   b. Please provide details on the exact diagnosis and symptom(s) experienced, including which body part affected, date of first and last symptoms.

Description of symptoms	
Date of first occurrence	
Date of last occurrence	

   c. Is the condition cancerous or non-cancerous?
   ☐ Cancerous ☐ Non-cancerous

2. a. Have you had or are you undergoing or awaiting referral, investigation or surgery for this condition?
   ☐ Awaiting surgery
   ☐ Surgery done
   ☐ Investigation done
   ☐ Awaiting referral or investigation
   ☐ Advised for surgery or investigation but do not plan to do so
   ☐ I have not been advised for further investigation or surgery

   b. Please state the date of referral or surgery (if applicable).

   _____ (dd/mm/yyyy)

   c. Please provide type of surgery advised or done (if applicable).

   _____

   d. Name of specialist you had been referred to (if applicable).

   _____

3. What are the investigation, test or examination you had done? Please select all that are applicable.
   ☐ Blood Test
   ☐ Urine Test
   ☐ Ultrasound
   ☐ X-ray
   ☐ Stool Test
   ☐ Electrocardiogram (ECG)
   ☐ Exercise Treadmill ECG
   ☐ Echocardiogram
   ☐ Pap Smear
   ☐ Breast Screen (e.g. Mammogram of Breast, Breast Ultrasound)
   ☐ CT Scan (Computerised Tomography Scan)
   ☐ MRI (Magnetic Resonance Imaging)
   ☐ Gastroscopy / Colonoscopy
   ☐ Prostate Check (e.g. physical prostate check, PSA test, prostate ultrasound, etc)
   ☐ Other test(s), please specify: _____
   ☐ Not applicable

   Please provide details on the investigation, test or examination you had done as above.

Type of tests	Results	Date of tests

Details of insured

Full name (as in NRIC/BC/Passport/Long-Term Pass)	NRIC/BC/Passport number/FIN	Proposal number(s)

Medical Condition:

Questions for insured (continued)

4. Have you had or been advised to have any treatment for this condition?

☐ Yes (please provide details below) ☐ No

Name or description	Dosage	Date or period

5. Have you ever been hospitalised?

☐ Yes (please provide details below) ☐ No

Please enclose a copy of inpatient discharge or clinical summaries. ☐ Enclosed ☐ Not available

Date	Duration of stay	Reason or diagnosis	Name of hospital

6. a. Please provide name of your doctor.

_____

b. Please provide name of the clinic or hospital.

_____

7. What is the current status of your condition?

☐ Have fully recovered and discharged from medical follow-up on _____ (dd/mm/yyyy)
(i.e. no recurrence, no symptom, no complication and no resulting disability or restriction in activities)

☐ Currently still on follow-up or monitoring.
Frequency of follow-up: _____ When was your last follow-up? _____ (dd/mm/yyyy)

☐ No follow-up required.

☐ Any other information you wish to share with us.

8. Medical Report

Please submit all medical reports available including inpatient discharge summary, doctor's report, investigation report, histology report, etc.

☐ Attached ☐ Not available

Details of insured

Full name (as in NRIC/BC/Passport/Long-Term Pass)	NRIC/BC/Passport number/FIN	Proposal number(s)

Medical Condition:

Declaration by the proposer and insured

I cannot alter any of the wordings in this form. Any attempt to do so will have no effect.

I declare that the answers given in this form are true, correct and complete. I accept full responsibility for them, whether written by me or by anyone else on my behalf. I have not withheld any information. If it is discovered later that I or the Insured suffer from a medical condition that is not disclosed in this form, I will not be entitled to rely on the defence that the information was disclosed for or in the records of other policies with Income. I agree that this form and other written answers, statements, information or declarations I have made or which have been made on my behalf will form the basis of the contract of insurance between the policyholder and Income. If anything is untrue, incorrect or incomplete, the insurance policy will not be valid.

I confirm that there has been no change in my health or the Insured's health since the completion of the application and all additional declarations made in connection with the application. I will notify Income immediately if there is any change in the state of my health or the Insured's health, or if I or the Insured plan to seek medical consultation, investigation, or treatment between the date of this application and the date this policy is in force. I am aware that Income may add special terms to the policy or declare the policy as void according to the information provided or if I fail to notify Income of any change in the state of my health or the Insured's health.

I acknowledge and agree that this form will constitute part of my application for life or health insurance, and will form the basis of the contract of insurance.

I confirm that I understand and agree to the 'Personal Data Use Statement' and declaration set out in my policy application form which I have submitted to Income. I understand that I can refer to Income's Privacy Policy for more information, including access and correction of my personal data and consent withdrawal.

I agree that if I do not reveal any significant fact (which would have affected Income's decision to accept my application on standard terms), any policy issued may be invalid. This includes any facts I may not be sure is significant, and any information I have given to my advisor but was not included in this form.

Signature of proposer	Signature of insured (for age 16 and above)
Date (dd/mm/yyyy):	Date (dd/mm/yyyy):