



## AIA SINGAPORE

### HEALTH DECLARATION FORM

#### Corporate Solutions

3 Tampines Grande, AIA Tampines #07-00, Singapore 528799 Fax: (65) 6538 5603 / 6538 4340  
Email: sg.eb.singtelunderwriting@aia.com

**Important Note:** Pursuant to Section 25(5) of the Insurance Act and replacement thereof, you are to disclose in this form, fully & faithfully, all the facts which you know, otherwise the policy issued hereunder may be void.

#### POLICY INFORMATION

Policy Number	Name of Company
7 7 2 0 0 -	SINGAPORE TELECOMMUNICATIONS LIMITED

#### EMPLOYEE'S INFORMATION

Name (According to NRIC / Passport) – Please underline Surname										
ANAND NARAYANA VADIVU										
NRIC / Passport / FIN Number					Nationality					
S 7 6 5 8 8 5 9 G					INDIAN					
Gender		Marital Status		Date of Birth			Height	172	cm	Contact Number
Male <input checked="" type="checkbox"/> Female <input type="checkbox"/>		Single <input type="checkbox"/> Married <input checked="" type="checkbox"/>		Day	Month	Year	Weight	81	kg	8 1 8 9 8 4 0 1
Occupation										
Staff Software Engineer										
Email Address										
nanandmca@yahoo.com										

#### DEPENDANT(S) PARTICULARS – (to complete only if you are buying voluntary cover for your spouse & children)

Relationship	Name (Full name as shown in NRIC/Passport)	NRIC/ Passport No.	Nationality	Occupation	Gender (M/F)	Date of Birth (DD/MM/YYYY)	Height (cm)	Weight (kg)
Spouse	ANUSUYA MUTHU KRISHNAN	S8468684J	INDIAN	Homemaker	<input type="checkbox"/> M / <input checked="" type="checkbox"/> F	28/07/1984	160	59
1 <sup>st</sup> Child	ARATHANA ANAND	T1074751H	INDIAN	Student	<input type="checkbox"/> M / <input checked="" type="checkbox"/> F	15/05/2010	142	31
2 <sup>nd</sup> Child	ANANTHANAA ANAND	T1174356G	INDIAN	Student	<input type="checkbox"/> M / <input checked="" type="checkbox"/> F	19/11/2011	138	33
3 <sup>rd</sup> Child					<input type="checkbox"/> M / <input type="checkbox"/> F			

#### FAMILY HISTORY of the EMPLOYEE and DEPENDANT(S) (IF APPLICABLE)

Have any of your natural parents or sibling(s) suffered from cancer\*\*, heart disease, stroke, high blood pressure, diabetes, kidney disease, mental disorder, tuberculosis or any hereditary disease(s)? Please tick : Yes  or No

**IF YES, PLEASE PROVIDE DETAILS BELOW (\*\* for Cancer, please specify type of cancer)**

Name of Employee/Dependent	Relationship (to Insured)	Medical Condition (Diagnosis)	Age at time of Diagnosis	Age of Death (If Deceased)	Cause of Death (If Deceased)
ANAND NARAYANA VADIVU	Father	Diabetes	50		
ANUSUYA MUTHU KRISHNAN	Father	Diabetes	47		

**MEDICAL QUESTIONNAIRE**

<b>All 11 questions must be answered</b>		<b>Complete ONLY IF to be insured</b>				
		<b>Employee</b>	<b>Spouse</b>	<b>1<sup>st</sup> Child</b>	<b>2<sup>nd</sup> Child</b>	<b>3<sup>rd</sup> Child</b>
1	Do you engage in any sports(s) or occupation of a dangerous or hazardous nature such as motor racing, scuba/skin diving, parachuting, military (excluding NS) or private flying other than as a fare paying passenger, etc.?  <b>If yes, please furnish details in the box on page 4</b>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
2	Has any of your application / reinstatement for life, critical illness, accident, disability income, medical insurance ever been declined, postponed, or accepted with special terms (eg: extra premium loading or exclusion imposed)?  <b>If yes, please furnish details in the box on page 4</b>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
3	a) Have you ever used addictive drugs, narcotics, glue sniffing or been treated for drug addiction?  b) Have you ever had or been treated for alcoholism?  <b>If yes, please furnish details in the box on page 4</b>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
4	Do you drink wine, beer or other alcoholic beverages? If yes, please furnish details :  a) Type of alcohol : (Beer / Wine / Others, please specify)  b) Frequency : (number of times per week)  c) Quantity : (mls / units per week)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
5	Have you ever smoked cigarettes in the last 12 months?  If yes, please provide details :- a) Number of sticks per day :	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
6	a) Have you received any medical advice, counselling or treatment in connection with sexually transmitted disease, AIDS Related Complex or any other AIDS related condition  b) Have you ever had HIV testing done? If yes, please state the reason and its results.  <b>If yes, please furnish details in the box on page 4</b>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
7	In the past 3 months, have you ever had any of the following symptoms for more than one week continuously: Fatigue, weight loss, enlarged node(s) or unusual skin lesion(s)?  <b>If yes, please furnish details in the box on page 4</b>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
8	In the past 5 years, have you ever undergone or been advised to undergo any medical investigation(s) carried out on the recommendation of a doctor such as X-ray, Ultrasound, Heart scan, CT scan, Biopsy, Endoscopy, Gastroscopy, Colonoscopy, Surgical operation, etc.?  <b>If yes, please furnish details in the box on page 4</b>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			

**MEDICAL QUESTIONNAIRE**

All 11 questions must be answered		Complete ONLY IF to be insured				
		Employee	Spouse	1 <sup>st</sup> Child	2 <sup>nd</sup> Child	3 <sup>rd</sup> Child
9	Have you EVER had or been told you had or been treated for:	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>			
	a) Asthma, coughing with blood, pneumonia, tuberculosis, bronchitis, breathing discomfort or breathlessness and/or any other lung disease/disorder?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>			
	b) Rheumatic fever, high blood pressure, heart murmur, heart attack, coronary artery disease, mitral valve prolapse, or other heart valve disorder, irregular or fast heart rate, chest discomfort or chest pain, and / or any disease or disorder of the heart or blood vessels?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>			
	c) Renal/bladder stone(s), albumin/protein in urine, blood or sugar in urine, urine infection or any other disorder of the kidney(s), bladder, urinary or genital organs?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>			
	d) Epilepsy, fits, stroke, paralysis, dementia, Parkinson's disease, multiple sclerosis, motor neurone disease, weakness of limbs, polio, fainting spells, prolonged headache, anxiety, depression, or any other nervous or mental disorder(s) or disease of the brain?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>			
	e) Diabetes, thyroid disorder(s), or any other endocrine disorder(s)	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>			
	f) Gastritis, ulcer, blood in stools, fistula, hernia, irritable bowel syndrome, or any other disease/disorder of the stomach or bowel	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>			
	g) Hepatitis B carrier or any form of hepatitis, jaundice, liver disorder or gall bladder disorder	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>			
	h) Ear discharge, nose bleeding, double vision, impaired sight, hearing or speech, or any other disorder of the ear(s), eye(s), nose, or throat?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>			
	i) Slipped disc, back pain, gout, any form of arthritis, joint pain or deformity, and / or any disease/disorder of the muscles, spine, limbs or joints or severe injury?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>			
	j) Anaemia, any other disorders of the blood, or advised to abstain from donating or received blood transfusion?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>			
k) Cancer, tumour(s), cyst(s) or growth(s) of any kind?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
l) Congenital anomalies, physical disability or any other illness, disorder, operations, hospital admission, accident or injury not mentioned above?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>If yes, please furnish details in the box on page 4</b>						
<b>For Female Applicants only (including children age 12 year and above)</b>						
10	a) Have you ever been to any doctor for a Pap Smear (cervical smear)? If yes, please state result : (i) Result : (Normal / Abnormal)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	b) Have you ever had any abnormal pap smear test or been told by any doctor to have a repeat pap smear within 6 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	c) Have you ever been found to have or are you aware of any breast cyst(s) /lump(s) /nodule(s) or any other disease or disorder of the breast(s)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	d) Have you ever suffered from irregular, painful or unusually heavy menstruation, fibroid(s), cyst(s) or any other disorder involving the female organ(s)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>If yes, please furnish details in the box on page 4</b>						
11	a) Were there any complication(s) noted during any of your pregnancy such as gestational diabetes, hypertension etc.? If yes, please provide details. (i) Details :	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	b) Are you currently pregnant?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	If yes, please state weeks of pregnancy :	_____	_____	_____	_____	_____

If any of the answers is "Yes", please give full details in the space provided below

Qn. No.	Name of Insured	Please provide date of consultation, details of diagnosis/exact condition, result, name and address of doctor seen

**DECLARATIONS**

1) I hereby declare and confirm that I have read and understood the contents of "Your Guide to Health Insurance" (applicable only to accident and health business), "Your Guide to Life Insurance" and "Product Summary". (Applicable if coverage is on voluntary basis).

2) I/We hereby authorise, agree and consent to:

(a) persons and organisations, whether within or outside Singapore, including but not limited to medical sources, hospitals, doctors, other healthcare professionals, laboratories, regulator, dispute resolution centres and insurers, their associated persons/ organisations, my/our or the insured person's employers or financial service providers, or their third party service providers or representatives (collectively "Third Parties") disclosing and releasing to AIA Singapore Private Limited ("AIA Singapore"), its associated persons/organisations, its and their third party service providers and its and their representatives, whether within or outside Singapore (collectively "AIA Persons"), any information concerning the policy owner and the insured person(s) at any time, including all personal data and information, medical information, medical history, consultation history and notes, prescriptions, treatments, descriptions of medical services rendered, and any employment and financial information, including the taking of copies of such records (collectively "Personal Data"), relevant for the Purpose (defined below);

(b) the AIA Persons sharing the scope of sub-clause (a) above, along with any of the Personal Data, with any relevant Third Parties to procure their disclosure and release of additional relevant Personal Data for the Purpose;

(c) the AIA Persons, including their approved medical examiners or laboratories, performing any necessary medical assessments and examinations and tests to determine, assess and evaluate the health of the insured person(s);

(d) the AIA Persons collecting, using, disclosing, storing, retaining and/or processing (collectively, "Using"/"Use") the Personal Data for the Purpose; and

(e) waive any right (on my own behalf and on behalf of the insured person(s) where applicable, in respect of which I/we represent and warrant that the insured person(s) have granted me/us authority to so waive) to bring a claim of any nature against any of the AIA Persons in respect of any above-mentioned Use and/or any Use of any Personal Data for the Purpose.

Where I/we are not the insured person, I/we represent and warrant that I/we have obtained the consent of the insured person(s), except to the extent such consent is not required under relevant laws: (i) to collect their Personal Data; (ii) to disclose their Personal Data to the AIA Persons; and (iii) for the AIA Persons and Third Parties to Use any of their Personal Data in the manner and for the purposes described in this Clause. I/We hereby agree to indemnify AIA Persons for all losses and damages that AIA Persons may suffer in the event that I/we are in breach of any representation and warranty provided by me/us herein. In this Clause, "Purpose" means any of the purposes described in the AIA Personal Data Policy, including but not limited to processing of this form, to provide subsequent advice or services to me/us or the insured person in relation to any existing or future policy/policies/programmes that I/we may hold/participate with AIA Singapore. This authorisation shall bind my/our successors and assigns, and remains valid, notwithstanding death, irrespective of whether or not my/our Application/form is accepted by AIA Singapore. A photocopy of this authorisation shall be valid and effective as the original.

3) I understand and agree that AIA Singapore is entitled not to accept or process this form should I or any of my dependents be found to be a Prohibited Person, meaning a person/entity subject to any laws, regulations and/or sanctions administered by any regulatory authorities in any country, which have the effect of prohibiting AIA Singapore from providing insurance coverage, transacting business with or otherwise offering any economic benefits to me/my dependents or any other beneficiary under the Policy, and the decision of AIA Singapore shall be final. I/We further agree that in the event that AIA becomes aware subsequently that the Policyholder/myself/any of my dependents has become a Prohibited Person, AIA Singapore may block and/or terminate the Policy with immediate effect, remove myself or my dependents from coverage under the Policy and shall not thereafter be required to transact any business with the Policyholder and/or myself/my dependents in connection with the Policy, including but not limited to, making or receiving any payments under the Policy.

4) I/We further agree that this form may be signed and delivered by facsimile, electronic mail or other electronic means, including via a website or electronic portal designated by AIA Singapore. A copy of such form received via any of the above means may be stored electronically or using other means by or under the authority of AIA Singapore and such copy shall have the same legal effect and validity as if it were the original.

**WARNING:** If a material fact is not disclosed in this proposal, any policy issued may not be valid. If you are in doubt as to whether a fact is material, you are advised to disclose it. This includes any information that you may have provided to the Financial Services Consultant(s)/ Insurance Representative(s) but was not included in the proposal. Please check to ensure you are fully satisfied with the information declared in this proposal. Additionally and without prejudice to the parties' rights and obligations whether under law or otherwise, you must continue to disclose any and all material facts that may arise or which have changed from the information you had provided.

Declared in SINGAPORE on:	02	(Day)	06	(Month)	2021	(Year)			
	Anand Narayana Vadivu			Anusuya Muthu Krishnan					
N. Anusuya				Anusuya M					
NAME & SIGNATURE OF EMPLOYEE				NAME & SIGNATURE OF SPOUSE (IF APPLICABLE)					