

MediWell Plus / MediLite – Health Declaration Form



Important Notice

- Statement Pursuant to Section 25(5) of the Insurance Act you are to disclose to us fully and faithfully the facts you know or ought to know otherwise you may not receive any benefits from your Policy.
- Please answer every applicable question and furnish complete details to avoid unnecessary delay in the processing of this application. Any question not answered will be taken as an answer in the negative.
- This form is valid for three months from date of application, after which has to be re-completed and signed.

Personal Insurance Application Form

Agent Name / Code :

The Policyholder

Name : _____ Policy No. : _____
 Tel : _____ (Mobile) _____ (H) _____ (O)

Particulars of Person Concerned

Name : _____
 NRIC/Passport/ROC No. : _____ Height : metres Weight : kg Gender* : M / F
 (whichever applicable)
 Nationality : _____ Date of Birth (dd/mm/yy) : _____
 Occupation & Business / Trade : _____

• Delete as appropriate

Reason of Application

- ¹Upgrading of Plan ¹Addition of Optional Riders ¹Removal of Deductible/Co-insurance
 Review Medical Rating / Exclusion Declaration of New Medical Condition(s) Others (please specify): _____

1. Kindly submit MediWell Plus/MediLite Amendment Form with this application

Habits of Person Concerned

Have you / the person to be insured been smoking in the past 12 months? Yes / No
 If yes, please specify: No. of years of smoking _____ No. of cigarettes per day _____
 Do you / the person to be insured consumes beer, wine or other alcohol? Yes / No
 If yes, please specify:
 Beer _____ cans (330ml) Wine _____ glasses (100ml) Spirits _____ tots (30ml) per week
 Others (please specify type and amount of consumption): _____
 Have you and the person(s) to be insured ever taken any habit forming drugs or been treated for drug addiction? Yes / No
 Do you / the person to be insured engage in or intend to engage in any sports of hazardous nature (e.g. diving, flying, motor-racing etc)? If yes, please give details: Yes / No

Health Declarations

You may be required to complete a separate questionnaire or submit a medical report (expenses to be borne by you) for any health conditions declared below.

- Have you had any health screening with abnormal results during the last 2 years? Yes / No
- Have you ever
 - had a surgical procedure? Yes / No
 - been advised to have any diagnostic test, hospital confinement or surgical procedure which has not yet been performed? Yes / No
 - received any medical advice, counseling or treatment in connection with sexually transmitted disease (e.g. gonorrhoea, syphilis, genital warts/herpes, non-specific urethritis), HIV infection or AIDS? Yes / No
- Are you currently undergoing any medical treatment for, ever been treated for, under observation for, or have been told of, any disorder or disease of the following:-
 - Ears, nose, throat, eyes, cataracts, glaucoma, detached retina, sinusitis, otitis media, hearing problem? Yes / No
 - Digestive system, liver, gallbladder, stomach, pancreas, intestines, hepatitis, cirrhosis, stones, hernia, gastritis, ulcer, gastric/intestinal polyp, piles/haemorrhoids, fistula, chronic diarrhoea, irritable bowel disease, rectal bleeding? Yes / No
 - Respiratory system, chest or breathing discomfort, lung conditions, asthma, bronchitis, pneumonia, persistent cough, tuberculosis, pneumothorax, nasal bleeding, nasal polyps, sinusitis? Yes / No
 - Heart attack, angina, chest pain, rheumatic fever, murmur, heart valve disorder, irregular or fast heart rate, coronary artery disease, high blood pressure, high cholesterol or any disease or disorder of the heart or the blood vessels? Yes / No
 - Diabetes, thyroid gland, pituitary gland or any disease or disorder of the endocrine system? Yes / No
 - Brain, mental or nervous system disorder, fits, epilepsy, paralysis, stroke, weakness of limb, numbness, poliomyelitis, migraine, prolonged headache, loss of balance, dizziness, fainting spells, anxiety or depression? Yes / No
 - Albumin, protein, blood, sugar or pus in urine, kidney stones, urinary tract infection, prostate problem, incontinence or any disease or disorder of the kidney, bladder or genitourinary system? Yes / No
 - Gout, arthritis, slipped-disc, persistent back / neck pain, osteoporosis, Systemic Lupus Erythematosus (SLE) or any disease or disorder of the spine, bones, limbs, joints, muscles or connective tissues? Yes / No
 - Cancer, tumour, cyst or growth of any kind? Yes / No

MediWell Plus / MediLite – Health Declaration Form

- | | |
|---|----------|
| j. Anaemia, thalassaemia, haemophilia or any disease or disorder of the blood? | Yes / No |
| k. Physical defects/deformities, congenital anomalies, premature birth? | Yes / No |
| l. Skin problem, drug allergy or any other illness, disorder, physical disability or injury not listed above? | Yes / No |
| m. Any other illnesses not listed above, please give details on separate sheets. | Yes / No |
| 4. During the past five years have you consulted a physician for a general examination or for any reasons not previously noted on this application? | Yes / No |
| 5. Have any of your natural parents or any siblings died or suffered from cancer, heart disease, kidney disease, stroke, diabetes, high blood pressure, mental disorder, tuberculosis or any contagious disease or any hereditary disease or disorder? If yes, please give details: | Yes / No |

Relationship	Age at Onset	Current Age / Age at Death	Diagnosis

For Females only (Question 6 and 7)

- | | |
|--|----------|
| 6. Have you ever suffered from or been treated for any disease or disorder of the breasts or female organs (uterus, ovary, fallopian tube, cervix, etc) including abnormal Pap smear and irregular menses? | Yes / No |
| 7a. Are you now pregnant?
Expected delivery date: _____ | Yes / No |
| 7b. Any complication(s) relating to this / previous pregnancies?
If yes, please specify: *Gestational Diabetes / Eclampsia / Hypertension / Others (please state): _____ | Yes / No |

If you answer 'Yes' to questions 1 to 4, 6 to 7, please provide full details:

Qn No.	Nature or Diagnosis of Illness / Injury	Date of diagnosis	Type of Treatment	Date of Treatment	Date of Last Consultation	Result of Last Consultation	Name & Address of Physician

Remarks:

- | | |
|---|----------|
| 8. Has any proposal or application made by you for a Life, Accident or Health policy insurance ever been declined, postponed or accepted at other than normal terms, cancelled or renewal refused? If yes, please give details / reasons: | Yes / No |
| 9. Have you ever made a claim against any Insurance Company in respect of bodily injury or sickness during the past 3 years?
If yes, please give details: | Yes / No |

Nature or Diagnosis of Illness / Injury	Date of Diagnosis / Disability	Type of Treatment	Result of Treatment	Paid Claims	Outstanding Claims

Declaration

I hereby declare to the best of my knowledge and belief that the statements and answers given in this health declaration are true and complete and that I have not withheld any information or material facts that may influence the assessment and acceptance of this insurance. I understand that any misstatement of fact, whether by commission or omission may be grounds for Tenet Insurance Company Ltd. in its absolute and sole discretion to decline to pay any benefit which might otherwise have been payable.

I agree that this proposal and declaration shall be the basis of the contract between me and Tenet Insurance Company Ltd. and shall be deemed to be incorporated in such contract. I understand that this insurance if accepted will be an annual contract renewable at the discretion of Tenet Insurance Company Ltd.

Signature of Insured Member / Person to be Insured
(If Insured Member is under age 19, signature of Applicant is required)

Date