Etiqa Insurance Pte Ltd (Company Reg. No. 201331905K)
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Health Declaration Form

WARNING: PURSUANT TO SECTION 23(5) OF THE INSURANCE ACT 1966, YOU ARE TO DISCLOSE IN THIS PROPOSAL FORM FULLY AND FAITHFULLY, ALL THE FACTS WHICH YOU KNOW OR OUGHT TO KNOW, OTHERWISE THE POLICY MAY BE VOID.

1. PERSONAL DETAILS OF PROPOSER / LIFE TO BE INSURED

Type of Details	Details of Proposer	Details of Life to be Insured (If different from Proposer)
Full Name (As shown in NRIC / Passport)		
Nationality		
Citizenship (for Singapore PR)		
Residency Status		
Smoker	☐ Yes ☐ No	☐ Yes ☐ No
Occupation		
Name of Employer		
Nature of Business / Industry		
Annual Income	S$	S$
Source of Funds	☐ Employment ☐ Sale of Assets ☐ Savings ☐ Maturity / Surrender of Policy ☐ Others, please specify: _____	☐ Employment ☐ Sale of Assets ☐ Savings ☐ Maturity / Surrender of Policy ☐ Others, please specify: _____

2. UNDERWRITING QUESTIONS

A. DECLARATION & REPLACEMENT OF EXISTING INSURANCE APPLICATION

1. Do you have any existing policy or proposal with us or any other insurer pending approval? If Yes, please provide details below	☐ Yes ☐ No	☐ Yes ☐ No

Proposer

Name of Insurer	Year Issued	Currency	Sum Insured (S$)				
			Life	Total & Permanent Disability	Critical Illness	Accident & Hospitalisation	Others

Life Insured

Name of Insurer	Year Issued	Currency	Sum Insured (S$)				
			Life	Total & Permanent Disability	Critical Illness	Accident & Hospitalisation	Others

2. Has any application or reinstatement for a life/critical illness/disability/accident or hospital insurance policy ever been refused, postponed or accepted at special terms by us or any insurer? If Yes, please provide details below:	☐ Yes ☐ No	☐ Yes ☐ No

	Proposer	Life Insured
Name of Insurer		
Type of Policy		
Reason		

2. UNDERWRITING QUESTIONS

A. DECLARATION & REPLACEMENT OF EXISTING INSURANCE APPLICATION (Continue)

	Proposer	Life Insured
3. Have you ever made any claims or are you intending to make any claims, on any policy with any insurer (for example: critical illness, disability, terminal illness, accident or hospitalisation)? If Yes, please provide details below:	☐ Yes ☐ No	☐ Yes ☐ No

	Proposer	Life Insured
Name of Insurer		
Year & Nature of Claim		
Reason of Claim		

B. LIFESTYLE DETAILS

	Proposer	Life Insured
1. Do you consume alcohol? If Yes, please state the quantity of alcohol you drink per week	☐ Yes ☐ No	☐ Yes ☐ No

Proposer				Life Insured			
Can of Beer *(330ml)*	Glasses of Wine *(100ml)*	Tots of Spirits *(30ml)*	Others	Can of Beer *(330ml)*	Glasses of Wine *(100ml)*	Tots of Spirits *(30ml)*	Others

2. Have you used any tobacco products in the last 24 months (e.g. cigarette /cigar /nicotine /pipe / hookah etc.)?	☐ Yes ☐ No	☐ Yes ☐ No

Proposer			Life Insured		
Type of Tobacco	Years of smoking	No sticks per day	Type of Tobacco	Years of smoking	No sticks per day

3. Are you taking or have taken addictive drugs or substances (e.g. narcotics or glue sniffing)?	☐ Yes ☐ No	☐ Yes ☐ No

Proposer	Life Insured
Name of addictive drugs or substances	Name of addictive drugs or substances

4. Have you ever been treated or counselled for use of addictive drugs or substances or alcoholism?	☐ Yes ☐ No	☐ Yes ☐ No

Proposer	Life Insured
Name & address of Doctor	Name & address of Doctor

5. Do you take part in or do you plan to take part in military or private flying other than as a passenger on a regular airline or any other dangerous occupation or pursuits such as scuba diving, mountain or rock climbing, free-fall parachuting, sky diving or motor racing? If Yes, please complete the Questionnaire.	☐ Yes ☐ No	☐ Yes ☐ No

C. TRAVEL DECLARATION

1. Have you travelled outside of Singapore within the last 14 days?	☐ Yes ☐ No	☐ Yes ☐ No

Proposer

Country	City	Date Arrived	Date Departed	Purpose of Travel

Life to be Insured

Country	City	Date Arrived	Date Departed	Purpose of Travel

2. In the next 3 months, do you have any plans to travel outside of Singapore?	☐ Yes ☐ No	☐ Yes ☐ No

Proposer

Country	City	Date Arrived	Date Departed	Purpose of Travel

Life to be Insured

Country	City	Date Arrived	Date Departed	Purpose of Travel

D. DETAILS OF REGULAR DOCTOR

	Proposer	Life Insured
1. Do you have a doctor whom you consult for medical reasons other than minor illness such as common cold or flu? If Yes, please provide details below:	☐ Yes ☐ No	☐ Yes ☐ No

	Proposer	Life Insured
Date of last consultation (dd/mm/yyyy)		
Reason for last consultation		
Name & address of Doctor		

E. HEALTH DETAILS

Important Notes:
If you answered "Yes" to any of the questions in Section E Q2 to Q4, Q7, Q10 and Q11, please provide details on following page

	Proposer	Life to be Insured
1. What is your Height and Weight	**cm** **kg**	**cm** **kg**
2. Have you ever had, or been told to have, or been told to seek treatment, or have been treated for any of the following medical conditions or symptoms?		
a. Epilepsy, fits, stroke, paralysis, weakness of limb, prolonged headache, unconsciousness, nervous breakdown, depression or any other nervous / mental disorders?	☐ Yes ☐ No	☐ Yes ☐ No
b. Diabetes, thyroid disorders or any other endocrine disorders, jaundice, hepatitis B carrier or any form of hepatitis, liver disorder or gall bladder disorder?	☐ Yes ☐ No	☐ Yes ☐ No
c. Ear discharge, nose bleeds, double vision, impaired sight, hearing or speech or any other disorders of ear, eye, nose or throat?	☐ Yes ☐ No	☐ Yes ☐ No
d. Asthma, bronchitis, persistent cough, coughing with blood, pneumonia, tuberculosis, chest or breathing complaints/discomfort or any other lung disorders?	☐ Yes ☐ No	☐ Yes ☐ No
e. Raised cholesterol, high blood pressure, heart attack, heart murmur, heart valve disorders, breathlessness, irregular or fast heart rate, chest discomfort or pain, disease of or any other disorders of the heart or blood vessels?	☐ Yes ☐ No	☐ Yes ☐ No

f.	Gastritis, stomach or duodenal ulcer, blood in stools, fistula, piles or any other oesophagus, stomach or bowel disorders?	☐ Yes ☐ No	☐ Yes ☐ No
g.	Systemic Lupus Erythematosus, rheumatic fever, rheumatoid arthritis, Kawasaki disease or any other disorders of the immune system?	☐ Yes ☐ No	☐ Yes ☐ No
h.	Blood, protein or sugar in urine, kidney stones, infection, urinary incontinence or any other disorders of the kidney, bladder, or genital organs?	☐ Yes ☐ No	☐ Yes ☐ No
i.	Slipped disc, gout, arthritis, osteoporosis, pain or deformity or disorders of the muscles, nerve, spine, limbs or joints or severe injury?	☐ Yes ☐ No	☐ Yes ☐ No
j.	Cancer, tumours, cyst or growths of any kind?	☐ Yes ☐ No	☐ Yes ☐ No
k.	Anaemia, any other disorders of the blood, advised to abstain from donating blood or received blood transfusion or blood products on account of haemophilia or any other reason?	☐ Yes ☐ No	☐ Yes ☐ No
l.	Any other illness, disorder, operation, physical disability or accident not mentioned above?	☐ Yes ☐ No	☐ Yes ☐ No
3.	Have you or your spouse been told to have, received any medical advice, counselling or treatment in connection with HIV, sexually transmitted disease, AIDS, AIDS Related Complex or any other AIDS related condition?	☐ Yes ☐ No	☐ Yes ☐ No
4.	Have you ever had HIV testing done (please state reason and results) or in the last 3 months had any of the following symptoms for more than 1 week continuously: fatigue, weight loss, diarrhoea, enlarged lymph nodes or unusual skin lesions?	☐ Yes ☐ No	☐ Yes ☐ No
5.	In the last 5 years, have you had, or been advised to undergo any medical tests or investigations? Or do you intend to have or awaiting for any tests or investigations in the coming year (e.g.) blood test, urine test, X-ray, ECG, ultrasound, imaging scan, biopsy, mammogram, Pap smear, prostate check)? If Yes, please provide details below and submit copy of the results, if any	☐ Yes ☐ No	☐ Yes ☐ No

	Proposer	Life Insured
Type of tests / investigations		
Date of tests / investigations (dd/mm/yyyy)		
Reason for tests / investigations		
Results of tests / investigations		
Name & address of clinic / hospital		

		Proposer	Life to be Insured
6.	Have any of your biological parents or siblings been diagnosed with or passed away as a result of: Alzheimer's disease, cancer, carcinoma-in-situ, heart disease, stroke, high blood pressure, diabetes, kidney diseases, mental disorder, tuberculosis or any hereditary disease prior reaching age 60? If Yes, please provide details below	☐ Yes ☐ No	☐ Yes ☐ No

	Proposer	Life Insured
Relationship to Proposer / Life to be Insured		
Medical Condition or Cause of Death		
Age at Condition onset		
Age at Death (if applicable)		

E. HEALTH DETAILS (Continue)

	Proposer	Life Insured
7. Have you experienced any of the following symptoms in the last 14 days: fever, sore throat, cough, shortness of breath, malaise, rhinorrhoea (mucus discharge from the nose), loss of sense of smell or taste. or gastro-intestinal symptoms such as nausea, vomiting and/or diarrhoea?	☐ Yes ☐ No	☐ Yes ☐ No
8. Within the past 14 days, have you had any contact with someone confirmed as infected with COVID-19?	☐ Yes ☐ No	☐ Yes ☐ No
9. Have you been tested positive for COVID-19?	☐ Yes ☐ No	☐ Yes ☐ No

If your answer is YES to question 9 above, please provide details below.

Proposer / Life to be Insured	Date of the positive test results	Any notice or directive to self-quarantine or stay home? (If yes, please state the date and duration)	Any hospitalisation (If yes, please state the date of admission and date of discharge)	Have you made a complete recovery without any complications? (Yes/No)	Was the recovery more than 3 months ago? (Yes/No)

10. Health Questions for Female only		
a. Have you suffered from or are you aware of the following: breast lumps or any other disorders of your breasts, irregular or painful or unusually heavy menstruation, fibroids, cysts or any other disorders of the female organs?	☐ Yes ☐ No	☐ Yes ☐ No
b. Have you ever had any abnormal pap smear test or been told by any doctor to have a repeat pap smear within the next 6 months?	☐ Yes ☐ No	☐ Yes ☐ No
c. Have you been advised to have a mammogram, biopsy, operation of the breasts, and ultrasound of the pelvis or any other gynaecological investigations? If Yes, copy of the test result to be submitted if available	☐ Yes ☐ No	☐ Yes ☐ No
d. Are you currently pregnant? If Yes, please state	☐ Yes ☐ No	☐ Yes ☐ No

	Proposer	Life Insured
No of Weeks Pregnant		
Estimated Delivery Date (dd/mm/yyyy)		

e. Have you had any complications during your pregnancy or as a result of your pregnancy (e.g. gestational diabetes, hypertension, eclampsia, etc.)?	☐ Yes ☐ No	☐ Yes ☐ No
11. Health Questions for Juvenile Life Insured only	Proposer (Not applicable)	Life Insured
Has the child ever suffered from, or currently suffering from, or being followed up or investigated for		
a. Premature birth or abnormal birth weight or delivery complications?	☐ Yes ☐ No	☐ Yes ☐ No
b. Congenital disorder/birth defect, any growth or developmental delay?	☐ Yes ☐ No	☐ Yes ☐ No
c. Mental retardation or autism, cerebral palsy, or Down's Syndrome?	☐ Yes ☐ No	☐ Yes ☐ No
d. G6PD deficiency?	☐ Yes ☐ No	☐ Yes ☐ No
e. Prolonged jaundice?	☐ Yes ☐ No	☐ Yes ☐ No
f. Respiratory distress syndrome?	☐ Yes ☐ No	☐ Yes ☐ No
g. Any other serious disorder?	☐ Yes ☐ No	☐ Yes ☐ No

If you answered "Yes" to any of the above questions in Section E Q2 to Q4, Q7, Q10 and Q11, please provide the details in the space below and submit a copy of the test result, if any:

Question No	Proposer or Life Insured	Condition & Date of Diagnosis	Name of Doctor	Name & Address of Hospital / Clinic	Remarks

F. DECLARATION OF GENETIC TESTS DONE

Important Notes:

- For Singapore Citizens/ Permanent Residents / Residents on Valid Passes, you are not required to disclose the result of any predictive genetic test conducted in the context of a biomedical research#. In the event of disclosure of a predictive genetic test result from a biomedical research, we will not use the results for risk assessment.
- For Non-Singapore Residents, you are required to disclose the result of any genetic test done under any circumstances, regardless of the sum assured.

 # Biomedical research refers to any systematic investigation with the intention of developing or contributing to generalizable knowledge, regardless of where or when the research was conducted or the nature of research.

Questions for Singapore Citizens / Permanent Residents / Residents with Valid Passes Only

	Proposer	Life Insured
1. Have you ever had a genetic test that is **NOT** done in the context of a biomedical research? If "**Yes**", please answer **Q2 and Q2a** (where applicable) and **Q3** (if you are applying for Critical Illness coverage) and **3a to 3c** (where applicable).	☐ Yes ☐ No	☐ Yes ☐ No
2. Is the Total Sum Insured# of your **Life and Total Permanent Disability cover exceeds S$2,000,000**? If **"YES"**, please answer **2a** and provide a copy of your result. *# Total sum insured includes your new application, concurrent or pending application(s) and all existing policies with us and other insurance company (ies).*	☐ Yes ☐ No	☐ Yes ☐ No
a. Have you ever had a predictive genetic test done for Huntington's disease?	☐ Yes ☐ No	☐ Yes ☐ No
3. Is the Total Sum Insured# of your **Critical Illness cover exceeds S$500,000**, If **"YES",** please answer **Q3a, 3b** and **3c** and provide copy of your result. *# Total sum insured includes your new application, concurrent or pending application(s) and all existing policies with us and other insurance company (ies).*	☐ Yes ☐ No	☐ Yes ☐ No
a. Have you ever had a predictive genetic test done for Huntington's disease?	☐ Yes ☐ No	☐ Yes ☐ No
b. Have you ever had a predictive genetic test done for breast cancer – BRCA1?	☐ Yes ☐ No	☐ Yes ☐ No
c. Have you ever had a predictive genetic test done for breast cancer – BRCA2?	☐ Yes ☐ No	☐ Yes ☐ No
Question for Non-Singapore Residents only		
4. Have you ever had a genetic test (excluding genetic test done in a biomedical research and Direct-to-Consumer context)? If you answer "**YES"**, please provide a copy of your result.	☐ Yes ☐ No	☐ Yes ☐ No

G. DECLARATION & AUTHORISATION

1. I/We declare that all the information given above is to the best of my/our knowledge, true and complete and I/we have not withheld any material information that may influence the assessment of my/our application. I/We further agree that the information given above shall form the basis of my/our application for insurance, reinstatement of policy, change of plan and any material fact known to me/us may invalidate the contract of insurance.
2. I/We understand and agree that the changes requested in the application for insurance, reinstatement or change of plan: (a) may require medical evidence and I/we will pay any costs involved in providing the medical evidence Etiqa Insurance Private Limited ("the Company") needs (b) are subject the Company's underwriting and acceptance (c) If accepted, may be subject to terms, conditions and exclusions imposed by the Company and (d) will take effect only when the Company accepts and approves my/our application and notifies me/us in writing of the cover start date and provided that I/we have paid the required premiums (and interest if applicable) in full.
3. I/We agree to inform Etiqa Insurance Private Limited ("the Company") if there is any change in the Proposer / Life to be Insured's state of health or any information provided in the application form from the date I/we signed the application form to the issued date of my/our policy. I/W understand that the Company may vary the acceptance term or void the contract according to such information received.
4. If I/we am/are reinstating the policy, I/we agree that notwithstanding the terms and condition under the policy, I /we must give the Company all material information from the expiry date of my/our policy up till the reinstatement date that may influence the Company's decision whether to reinstate or to impose any further terms under the policy, if I /We fail to give the Company this material information or misrepresent, the Company may (a) declare the policy as void from the start date of the reinstated policy (b) end the cover for the insured and not pay any benefits or (c) change the acceptance terms of the policy . I/We further understand that the terms and conditions of my reinstated policy may be different from the terms and conditions of my policy prior to the reinstatement.
5. I/We authorise the Company to obtain, if necessary confidential reports from any doctor/clinic/hospital that I/we have referred above. I/we agree that a copy of the authorisation in this form is valid and binding as an original copy.
6. I have confirmed that I am not an undischarged bankrupt and no bankruptcy application (including any statutory order) or order has been made against me

I/We further agree and consent that Etiqa Insurance, Singapore, may collect, use, process and disclose the personal data in accordance with the terms and condition as stated in the insurance application form and/or the Etiqa Insurance, Singapore's Data Protection Policy available at www.etiqa.com.sg which I/We have read, understood and agreed to the same

Signature of Proposer or Assignee Date:	Signature of Life to be Insured (if different from Proposer and age 16 or above Date: