



Medical Examination Form (Juvenile)

For children aged 16 and below

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.

Full name of Life to be Insured (as shown in NRIC/Passport)

NRIC / Passport Number / FIN

Date of Birth (dd/mm/yyyy)

Gender

Male

Female

Full name of Proposer

NRIC / Passport Number / FIN

Statement to the Medical Examiner

What is the name and address of the child's regular doctor or any doctor that the child has visited in the last 3 years?

Name of Doctor

Address of Doctor/Clinic

Date and reason of the child's last visit to the doctor

Is the child currently taking any medication?

Yes No

If yes, please state reason and type of medication:

A. Lifestyle Details (to be completed for children aged 10 and above)

Please tick (✓) the relevant boxes.

If yes, please provide details

1 (a) Has the child used any tobacco products in the last 24 months? If yes, please indicate the date the child last smoked.

Yes No

(b) Does the child smoke currently?

Yes No

_____ sticks per day for _____ years

(c) Does the child consume beer, wine or other alcoholic beverage?

Yes No

____ can of beer (330ml) ____ glass of wine (per 125ml)
____ glass of spirit (per 30ml)

(d) Has the child ever taken addictive drugs / narcotics or been treated for alcoholism or drug addiction?

Yes No

B. Health Details

Please tick (✓) the relevant boxes.

If yes, please provide **FULL** details,

2 Has the child ever been told or treated for:

(a) Premature birth or abnormal birth weight or delivery complications?

Yes No

(b) Congenital disorder/birth defect, any growth or developmental delay?

Yes No

(c) 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

(d) Ear discharge, nose bleeds, double vision, impaired sight, hearing or speech or any other disorders of ear, eye, nose or throat?

Yes No

(e) Asthma, bronchitis, persistent cough, pneumonia, respiratory distress syndrome, chest or breathing complaints/discomfort or any other lung disorders?

Yes No

(f) Coeliac disease, prolonged jaundice, hepatitis, recurrent indigestion, gastritis, passage of blood or mucous from the bowel or any other disease or disorder of the liver, stomach, gallbladder, pancreas, bowel or intestines?

Yes No

(g) ic Lupus Erythematosus, rheumatic fever, rheumatoid arthritis, Kawasaki disease or any other disorders of the immune system?

Yes No

(h) Blood, protein or sugar in urine, kidney stones, infection, or any other disorders of the kidney, bladder, or genital organs?

Yes No

(i) Congenital deformity, mental retardation, muscular weakness, fracture or amputation or any other injury to or disease or disorder of the spine, bones, muscles or joints?

Yes No



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

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B. Health Details (cont'd)				
(j) Cancer, tumours, cyst or growths of any kind?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
(k) Anemia, thalassaemia, haemophilia, recurrent infection, or any other problem of disease or disorder of the immune system, blood, blood cells or bone marrow or any enlarged lymph node or other lymph node disorder?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
(l) Any other illness, disorder, operation, physical disability or accident not mentioned above?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
3 In the past 5 years, has the child had any:	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
(a) Tests done or been told to undergo tests such as X-ray, ultrasound, CT scan, biopsy, electrocardiogram (ECG), blood or urine test?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
(b) Illness, operation, medical advice, hospital treatment not mentioned above?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
4 Does the child have any other physical defects or health impairments?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
5 Does the child have any symptom or medical concern for which has not consulted a doctor or had any consultation, testing or investigation recommended by a doctor which has not yet be completed?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
6 Has the child's weight changed more than 5kg in the past year? If so, what is/are the reasons?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
7 Within the past 14 days, has the child had any contact with someone confirmed as infected with COVID-19?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
8 Has the child been issued any notice or directive to self-quarantine or stay home?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
9 Has the child been tested positive for COVID-19? If Yes, proceed to 9 (a) and (b)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
(a) Has the child been hospitalised for COVID-19? If yes, to state date of period admission and date of discharged	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
(b) Has the child recovered fully with no complications or sequelae?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
10 Has any proposal for coverage on the child's life ever been declined, withdrawn, postponed, rated, reinstated or modified in any way? If yes, please state name of insurer, reasons for substandard term or decline, acceptance term	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
11 Are you making or have you made any claims on the child, including hospitalisation claims on any policy with Etiqa or any other insurer? If yes, please state name of insurer, type of claims	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
C. Family History				
12 Has the child's biological parents or siblings been diagnosed with or passed away as a result of: Alzheimer's disease, cancer, carcinoma-in-situ, mental disorder, diabetes, polycystic kidney disease, stroke, high blood pressure, heart disease, or any other hereditary disease or disorder? If yes, please provide details below.				
Relationship	Type of Illness	Age / Year of Onset	Cause of Death (if deceased)	Age of Death (if deceased)
Declaration				
<p>1. I declare I am the parent / legal guardian of the child to be insured and that all the information given above are, to the best of my/our knowledge, true and complete and I have not withheld any material information that may influence the assessment of our application. I further agree that the information given above shall form the basis of our application for insurance and any material fact known to me may invalidate the contract of insurance</p> <p>2. I authorise Etiqa Insurance Private Limited ("the Company") to obtain, if necessary confidential reports from any doctor/clinic/hospital that I have referred above.</p> <p>3. I agree to inform Etiqa Insurance Private Limited ("the Company") if there is any change in my state of health or any information provided in this form from the date I signed to the issued date of my policy. I understand that the Company may vary the acceptance term or void the contract according to such information received.</p> <p>I further agree and consent that Etiqa Insurance Private Limited 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 have read, understood and agreed to the same.</p>				
Signature of Parent / Legal Guardian		Signature of Medical Examiner		
Name:		Name:		
NRIC:		NRIC:		
Date:		Date:		

Medical Examiner's Confidential Report

A. Physical Examination

Height _____ cm	Weight _____ kg													
Is there any recent significant weight change? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify.														
Is the above height and weight within the normal range? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please provide reason(s) for the abnormal range.														
Head Circumference for children up to 12 months: _____ (cm)	Percentile of Head Circumference: _____ %													
Visual Acuity	Left Eye	Right Eye												
Uncorrected														
Corrected														
Please tick (✓) the relevant boxes.		If yes, please provide FULL details of findings.												
1 (a) Is there any evidence of visual, hearing or speech impairment or eye, ear, nose or throat abnormalities?	<input type="checkbox"/> Yes <input type="checkbox"/> No													
(b) Hearing acuity: Are there any difficulties in hearing normal conversation?	<input type="checkbox"/> Yes <input type="checkbox"/> No													
2 (a) Is there any evidence of abnormality in the Central Nervous System and Musculo-skeletal System?	<input type="checkbox"/> Yes <input type="checkbox"/> No													
(b) Is there any abnormalities in gait, joint mobility, power, tone or reflexes?	<input type="checkbox"/> Yes <input type="checkbox"/> No													
(a) Are there any paralysis, tremors, or evidence of neurological abnormalities?	<input type="checkbox"/> Yes <input type="checkbox"/> No													
(b) Is there any evidence of diseases of the spine or joints?	<input type="checkbox"/> Yes <input type="checkbox"/> No													
(c) Is there any abnormality in the chest symmetry and movements?	<input type="checkbox"/> Yes <input type="checkbox"/> No													
(d) Percussion: Are there any areas of pathological dullness?	<input type="checkbox"/> Yes <input type="checkbox"/> No													
(e) Auscultation: Are there any abnormal breath sounds?	<input type="checkbox"/> Yes <input type="checkbox"/> No													
3 (a) Pulse Rate and Rhythm: If pulse is irregular or pulse >90 or <50/min, please repeat twice at intervals of 10 minutes each.	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="padding: 2px;">Pulse</td> <td style="padding: 2px;">1</td> <td style="padding: 2px;">2</td> <td style="padding: 2px;">3</td> </tr> <tr> <td style="padding: 2px;">Rate (per min)</td> <td style="padding: 2px;"></td> <td style="padding: 2px;"></td> <td style="padding: 2px;"></td> </tr> <tr> <td style="padding: 2px;">Rhythm</td> <td colspan="2" style="padding: 2px;"><input type="checkbox"/> Regular</td> <td style="padding: 2px;"><input type="checkbox"/> Not Regular</td> </tr> </table>		Pulse	1	2	3	Rate (per min)				Rhythm	<input type="checkbox"/> Regular		<input type="checkbox"/> Not Regular
Pulse	1	2	3											
Rate (per min)														
Rhythm	<input type="checkbox"/> Regular		<input type="checkbox"/> Not Regular											
(b) Is there any abnormality in the apex beat? State where the apex beat is felt.	<input type="checkbox"/> Yes <input type="checkbox"/> No													
(c) Are there any murmurs? If yes, please state type, site and grade.	<input type="checkbox"/> Yes <input type="checkbox"/> No													
(d) Is there any cyanosis or undue breathlessness on exertion?	<input type="checkbox"/> Yes <input type="checkbox"/> No													
(e) Is there any sign of hypertrophy or dilation?	<input type="checkbox"/> Yes <input type="checkbox"/> No													
4 (a) Are the liver, spleen and kidneys palpable?	<input type="checkbox"/> Yes <input type="checkbox"/> No													
(b) Is there any evidence of hernia, liver, spleen, or other abdominal abnormalities?	<input type="checkbox"/> Yes <input type="checkbox"/> No													
(c) Is there any evidence of diabetes, or disease of thyroid or endocrine glands?	<input type="checkbox"/> Yes <input type="checkbox"/> No													
(d) Is there any evidence of diseases of the urinary and genital organs?	<input type="checkbox"/> Yes <input type="checkbox"/> No													



A. Physical Examination (cont'd)

5 (a) Please test urine with a dipstick and indicate results. If any protein or blood results are "1+" or higher, please proceed with UFEME. For female, if blood is present, please state LMP.	Blood	Sugar	Albumin	Specific Gravity
(b) Is there any evidence of blood, protein or sugar in urine, kidney stones, infection or any other disorders of the kidney, bladder or genital organs?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
6 (a) Are there any scars or other signs of disease past or present?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
(b) Is there any visible growth, tumour or enlargement? If yes, please state its location and nature.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
7 (a) Is there any other evidence of illness, disorder, injury or disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
(b) Is there any significant change in the Examinee's appetite, weight and bowel habits recently?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
(c) Is there any further evidence of medical in the family history which you think are significant?	<input type="checkbox"/> Yes <input type="checkbox"/> No			

B. Doctor's Declaration

Please tick (✓) the relevant boxes.		If yes, please provide details
1. Have you seen the Examinee professionally before? If yes, we would appreciate it if you could review your records to confirm that all items of the Examinee's physical history has been declared.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Do you recommend any additional tests or reports?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Do you consider that there are any circumstances that may adversely affect the Examinee's life expectancy and risk of disability and dread diseases?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

I certify that I have this day examined and identified the Examinee who is the Life to be Insured named on this form.

The examination has been conducted in private on _____ (dd/mm/yyyy) at:

Clinic Name & Address: _____

Signature of Medical Examiner: _____

Name & Qualification: _____

Clinic Stamp