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

23 Church Street, #01-01 Capital Square, Singapore 049481 | T +65 6887 8777 | www.etiqa.com.sg

Medical Examination 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.

Full name of Life to be Insured (as shown in NRIC/Passport)		NRIC / Passport Number / FIN	Gender ☐ Male ☐ Female
Date of Birth (dd/mm/yyyy)	Age	Occupation	

Statement to the Medical Examiner

What is the name and address of your regular doctor or any doctor you have visited in the last 3 years?

Name of Doctor	Address of Doctor/Clinic

Date and reason of your last visit to the doctor

Are you currently taking any medication? ☐ Yes ☐ No

If yes, please state reason and type of medication:

A. Lifestyle Details

Please tick (✓) the relevant boxes.		If yes, please provide details
1 (a) Have you used any tobacco products in the last 24 months? If yes, please indicate the date you last smoked.	☐ Yes ☐ No	
(b) Do you smoke currently?	☐ Yes ☐ No	_____ sticks per day for _____ years
(c) Do you consume beer, wine or other alcoholic beverage?	☐ Yes ☐ No	_____ can of beer (330ml) _____ glass of wine (per 125ml) _____ glass of spirit (per 30ml)
(d) Have you 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 Have you ever been told or treated for: (a) Epilepsy, fits, stroke, paralysis, weakness of limb, prolonged headache, unconsciousness, nervous breakdown, depression or any other nervous / mental disorders?	☐ 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	
(c) Ear discharge, nose bleeds, double vision, impaired sight, hearing or speech or any other disorders of ear, eye, nose or throat?	☐ Yes ☐ No	
(d) Asthma, bronchitis, persistent cough, coughing with blood, pneumonia, tuberculosis, chest or breathing complaints/discomfort or any other lung disorders?	☐ Yes ☐ No	
(e) Raised cholesterol, high blood pressure, heart attack, heart murmur, cardiomyopathy, mitral valve prolapse or other 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	
(f) Gastritis, stomach or duodenal ulcer, blood in stools, fistula, piles or any other oesophagus, stomach or bowel disorders?	☐ Yes ☐ No	
(g) Systemic 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, urinary incontinence or any other disorders of the kidney, bladder, or genital organs?	☐ 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	

B. Health Details (cont'd)

(j) Cancer, tumours, cyst or growths of any kind?	☐ 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	
(l) Any other illness, disorder, operation, physical disability or accident not mentioned above?	☐ Yes ☐ No	
3 Have you or your spouse been told to have, received any medical advice, counselling or treatment in connection with sexually transmitted disease, AIDS, AIDS Related Complex or any other AIDS related condition, or 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	
4 In the past 5 years, have you had any: (a) Tests done or been told to undergo tests such as X-ray, ultrasound, CT scan, pap smear, biopsy, electrocardiogram (ECG), blood or urine test?	☐ Yes ☐ No	
(b) Illness, operation, medical advice, hospital treatment not mentioned above?	☐ Yes ☐ No	
5 Do you have any other physical defects or health impairments?	☐ Yes ☐ No	
6 Has your weight changed more than 5kg in the past year? If so, what is/are the reasons?	☐ Yes ☐ No	
7 Within the past 14 days, have you had any contact with someone confirmed as infected with COVID-19?	☐ Yes ☐ No	
8 Have you been issued any notice or directive to self-quarantine or stay home?	☐ Yes ☐ No	Period of quarantine
9 Have you been tested positive for COVID-19? If Yes, proceed to 9 (a) and (b)	☐ Yes ☐ No	
(a) Have you been hospitalised for COVID-19? If yes, to state date of period admission and date of discharged	☐ Yes ☐ No	Date of Admission and Date of Discharge
(b) Have you recovered fully with no complications or sequelaes?	☐ Yes ☐ No	
10 Has any proposal for coverage on your 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	☐ Yes ☐ No	
11 Are you making or have you made any claims, including hospitalisation claims on any policy with Etiqa or any other insurer? If yes, please state name of insurer, type of claims	☐ Yes ☐ No	

C. Family History

12 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, 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)

D. For Females Only

13 (a) Have you ever been found to have or are you aware of any breast lumps or disease(s) of the breasts?	☐ Yes ☐ No	
(b) Have you ever had recurrent / persistent irregular / painful / unusually heavy menstruation, fibroids, cysts or any other disorders of the female organs?	☐ Yes ☐ No	
(c) Have you ever been advised to have mammogram, biopsy, operation of the breasts, ultrasound of the breasts/pelvis, Pap smear test or any gynaecological investigations?	☐ Yes ☐ No	
(d) Have you ever had recurrent / persistent irregular / painful / unusually heavy menstruation, fibroids, cysts or any other disorders of the female organs?	☐ Yes ☐ No	
(e) Are you currently pregnant?	☐ Yes ☐ No	Weeks of pregnancy: _____ Estimated date of delivery (dd/mm/yyyy): _____
(f) Were there any complication(s) relating to this and/or previous pregnancies such as gestational diabetes, eclampsia etc? If so, please provide details.	☐ Yes ☐ No	

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

23 Church Street, #01-01 Capital Square, Singapore 049481 | T +65 6887 8777 | www.etiqa.com.sg

Declaration

1. I declare that all the information given above are, to the best of my knowledge, true and complete and I have not withheld any material information that may influence the assessment of my application. I further agree that the information given above shall form the basis of my application for insurance and any material fact known to me may invalidate the contract of insurance
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.
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.

I/We 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.

Signature of Examinee & Date	Witnessed by (Medical Examiner's name): NRIC: Date:

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

23 Church Street, #01-01 Capital Square, Singapore 049481 | T +65 6887 8777 | www.etiqa.com.sg

Medical Examiner's Confidential Report

A. Physical Examination

Height _____ cm	Weight _____ kg

Is there any recent significant weight change? ☐ Yes ☐ No
If yes, please specify.

Visual Acuity	Left Eye	Right Eye	Fundoscopy
Uncorrected			
Corrected			

For Males Only

Chest Inspiration (cm)	Chest Expiration (cm)	Abdomen (cm)

Please tick (✓) the relevant boxes.		If yes, please provide **FULL** details of findings.
1 (a) Does the Examinee appear to be in good health and a person of sober habits?	☐ Yes ☐ No	
(b) Does the appearance of the Examinee correspond with the age stated?	☐ Yes ☐ No	
(c) Is there any evidence of visual, hearing or speech impairment or eye, ear, nose or throat abnormalities?	☐ Yes ☐ No	
(d) Hearing acuity: Are there any difficulties in hearing normal conversation?	☐ Yes ☐ No	
2 (a) Is there any evidence of abnormality in the Central Nervous System and Musculo-skeletal System?	☐ Yes ☐ No	
(b) Is there any abnormalities in gait, joint mobility, power, tone or reflexes?	☐ Yes ☐ No	
(a) Are there any paralysis, tremors, or evidence of neurological abnormalities?	☐ Yes ☐ No	
(b) Is there any evidence of diseases of the spine or joints?	☐ Yes ☐ No	
(c) Is there any abnormality in the chest symmetry and movements?	☐ Yes ☐ No	
(d) Percussion: Are there any areas of pathological dullness?	☐ Yes ☐ No	
(e) Auscultation: Are there any abnormal breath sounds?	☐ Yes ☐ No	
3 (a) Blood Pressure: If it is found to be in excess of 140 Systolic or 90 Diastolic (5th phase), please take two further readings with intervals of 10 minutes each.		

	1	2	3
Systolic (mmHg)			
Diastolic (mmHg)			

(b) Pulse Rate and Rhythm: If pulse is irregular or pulse >90 or <50/min, please repeat twice at intervals of 10 minutes each.

Pulse	1	2	3
Rate (per min)			
Rhythm	☐ Regular	☐ Not Regular	

(c) Is there any abnormality in the apex beat? State where the apex beat is felt.	☐ Yes ☐ No	
(d) Are there any murmurs? If yes, please state type, site and grade.	☐ Yes ☐ No	
(e) Is there any cyanosis or undue breathlessness on exertion?	☐ Yes ☐ No	
(f) Is there any sign of hypertrophy or dilation?	☐ Yes ☐ No	

A. Physical Examination (cont'd)

4 (a) Are the liver, spleen and kidneys palpable?	☐ Yes ☐ No	
(b) Is there any evidence of hernia, liver, spleen, or other abdominal abnormalities?	☐ Yes ☐ No	
(c) Is there any evidence of diabetes, or disease of thyroid or endocrine glands?	☐ Yes ☐ No	
(d) Is there any evidence of diseases of the urinary and genital organs (e.g. varicocele calculus)?	☐ Yes ☐ No	
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?	☐ Yes ☐ No	
6 (a) Are there any scars or other signs of disease past or present?	☐ Yes ☐ No	
(b) Is there any visible growth, tumour or enlargement? If yes, please state its location and nature.	☐ Yes ☐ No	
7 (a) Is there any other evidence of illness, disorder, injury or disability?	☐ Yes ☐ No	
(b) Is there any significant change in the Examinee's appetite, weight and bowel habits recently?	☐ Yes ☐ No	
(c) Are there any special features in personal, recreational or occupational history which you think are significant?	☐ Yes ☐ No	
(d) Is there any further evidence of medical in the family history which you think are significant?	☐ Yes ☐ No	
For females only: 8 (a) Are there any lumps or lesions in the breasts, nipple or skin changes, and abnormal axillary nodes?	☐ Yes ☐ No	
(b) Are there any obstetrics or gynaecological abnormalities whether past/present e.g. miscarriage, abnormal Pap smear, fibroid, ovarian cysts, etc?	☐ Yes ☐ No	
(c) Is the Examinee currently having her menstruation?	☐ Yes ☐ 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.	☐ Yes ☐ No	
2. Do you recommend any additional tests or reports?	☐ Yes ☐ 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?	☐ Yes ☐ 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