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

Mental Health Questionnaire

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	Policy Number

A. Questions

1. What is the exact diagnosis of your condition?

2. Date of diagnosis of your condition

3. Please provide details of symptoms that you have experienced.

Symptoms	Date of first occurrence	Date of last occurrence

4. Are there any contributory factors to your condition? (e.g.) work stress, marital conflicts, death of close relative, drugs or alcohol abuse, etc. ☐ Yes ☐ No

   If yes, please provide details.

5. Has there been any recurrence of attacks in the past? ☐ Yes ☐ No

   If yes, please provide details.

Date	Details

6. Has any investigation been done? If yes, please provide details ☐ Yes ☐ No

Type of test(s)	Date of test(s)	Result of test(s)

7. Have you ever had any suicidal ideas, tendencies or suicide attempts? ☐ Yes ☐ No

   If yes, please provide details and date / period of occurrence

8. Has your mobility, work, studies or daily activities ever been affected or restricted by this condition? ☐ Yes ☐ No

   If yes, please provide details and date / period of occurrence

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A. Questions (continuation)

9. Have you consulted or been referred to a doctor (including specialist) for this condition? ☐ Yes ☐ No

Name & address of doctor	Date of first consultation	Date of last consultation	Result of last consultation

10. Have you been treated as an in-patient at any hospital or institution for this condition? ☐ Yes ☐ No

Name of hospital or institution	Treatment or procedure	Admission date	Discharge date

11. Have you been prescribed with any medications, therapy or treatment for this condition? ☐ Yes ☐ No

If yes, please provide details

Name of medication, therapy or treatment	Dosage	Start date	End date

12. Are you currently still on regular treatment or follow up with doctor? ☐ Yes ☐ No

If yes, please provide details

Frequency	Date of last consultation	Date of next consultation	Name & address of doctor

13. Please provide the name and address of the doctor/clinic consulted for your condition.

14. Please provide a copy of all reports and tests results that you have on your condition.

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B. Declaration and 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 and any material fact known to me/us may invalidate the contract of insurance.
2. I/We authorise the Company to obtain, if necessary confidential reports from any doctor/clinic/hospital that I/we have referred above.
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.

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