Respiratory Disorder Supplementary Questionnaire (Q27)

Particulars of Life Assured

Name : _____

Identity Card / Passport No. : _____ Contract No. : _____

Medical Questions

1. What was the diagnosis made by the doctor?

   _____

2. When was this condition diagnosed?

   _____

3. Please describe your symptoms (eg coughing, wheezing, shortness of breath, chest tightness):

   _____

   (a) Date of first occurrence of symptoms:

   _____

   (b) Number of attacks per year:

   _____

   (c) Date of last occurrence of symptoms:

   _____

   (d) Severity and duration of each attack:

   _____

   (e) Do your symptoms restrict your activities in any way?

   ☐ Yes ☐ No

   If '**Yes**', please provide details: _____

4. Are you aware of any specific factor which triggers your symptoms (eg exercise, stress, allergy)?

   ☐ Yes ☐ No

   If '**Yes**', please provide details: _____

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5. Do you smoke cigarettes or any form of tobacco?

☐ Yes ☐ No

If '**Yes**', please provide details. Number of sticks per day: _____ Number of years: _____

6. What treatment was or has been prescribed by your doctor?

Please tick accordingly and provide details:

☐ **Oral Medication**

Name of Medication	Dosage	Frequency	Start Date of Medication	End Date of Medication (if applicable)

☐ **Inhaler**

Name of inhaler	Dosage	Frequency	Date Of Last Treatment

☐ **Others**, please provide details: _____

Please specify date of last treatment (if applicable): _____

7. Have you undergone any investigations (eg x-ray, pulmonary function test)?

☐ Yes ☐ No

If '**Yes**', please provide details:

Type of Investigation / Test	Date	Results*
		☐ Normal ☐ Abnormal
		☐ Normal ☐ Abnormal
		☐ Normal ☐ Abnormal
		☐ Normal ☐ Abnormal
		☐ Normal ☐ Abnormal

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* For abnormal results, please provide details: _____

_____

8. Have you ever been admitted to hospital for this condition?

☐ Yes ☐ No

If '**Yes**', please provide details:

Name of Hospital	Date of Admission	Duration of Stay	Intensive Care Unit (ICU) or General Ward

9. Have you ever taken time off from work or school due to this condition?

☐ Yes ☐ No

If '**Yes**', please provide details:

Date	Duration of Time-off

10. Please provide the name and address of the doctor / clinic / hospital which you have consulted for this condition.

Name of Doctor / Clinic / Hospital	Address	Date of Last Consultation

Note: Please provide us with copies of all medical reports relating to this condition, if available.

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Declaration

I/We agree to inform Aviva Ltd if there is any change in my/our health status between the date of this Declaration and the date full insurance coverage is provided by Aviva Ltd to me/us. I/We understand that the terms of accepting me/us as a risk for insurance coverage may vary according to such information received.

I/We agree that the above information shall form the basis of my/our application for insurance. I/We declare that the information given is true and complete and I/we have not withheld any material information that may influence the assessment of my/our application.

_____	_____
Name and Signature of Life Assured	Date (dd/mm/yyyy)
_____	_____
Name and Signature of Assured	Date (dd/mm/yyyy)

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