



# AIA SINGAPORE HEALTH SCREENING QUESTIONNAIRE

## Particulars of Insured and Policy Owner

Name of Insured

NRIC/Passport/FIN No.



Name of Policy Owner

NRIC/Passport/FIN No.



## Policy Numbers







## Details

1. When did you undergo the most recent health screening (DD/MM/YY)?

2. What was the reason for health screening? E.g. medical condition, feeling unwell, routine screening etc.

3. Please provide names and addresses of doctors/ clinic who performed the recent health screening.

| Name of doctor | Name & address of clinic or hospital |
|----------------|--------------------------------------|
|                |                                      |

4. Please type of test performed in the health screening and the results.

| Type of Test                                       | Results (e.g. normal, abnormal, elevated, positive etc.) |
|--|--|
| <input type="checkbox"/> Blood Test                |  |
| <input type="checkbox"/> Biopsy                    |  |
| <input type="checkbox"/> Chest X Ray               |  |
| <input type="checkbox"/> CT Scan                   |  |
| <input type="checkbox"/> Mammogram                 |  |
| <input type="checkbox"/> MRI                       |  |
| <input type="checkbox"/> Heart Scan (CT Angiogram) |  |
| <input type="checkbox"/> Resting ECG               |  |
| <input type="checkbox"/> Treadmill ECG             |  |
| <input type="checkbox"/> Pap Smear                 |  |
| <input type="checkbox"/> Ultrasound - abdomen      |  |



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- Ultrasound - breast
- Ultrasound - pelvis
- Others, please specify

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5. Are you currently receiving medical treatment?

- Yes                       No

If **Yes**, please provide details:

6. Were you referred for further investigation / consultation (with cardiologist, urologist, gynaecologist, gastroenterologist etc.) due to the health screening result?

- Yes                       No

If **Yes**, please provide details:

7. Please provide a copy of the health screening report and further investigation report (if any).

- Enclosed                       Not available

**Declaration and Authorisation**

I confirm that the answers I have given are true, complete and accurate, and that I have not withheld any material information that may influence the assessment of acceptance of my Application. I acknowledge and confirm that this form constitutes an integral part of and is deemed incorporated into my Application Form for insurance(s) and that failure to disclose any material fact known to me may invalidate my insurance(s).

Signature of Insured

Date

Signature of Policy Owner/Assignee/Trustee

Date

FSC/IR's Name

FSC/IR's Code

FSC/IR Unit Name

Mobile No.

|  |  |  |  |
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