AIA SINGAPORE
NEUROLOGICAL DISORDER 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. Please state the precise diagnosis, or nature of the condition you are suffering from.

2. When was the condition first diagnosed? (Month/ Year)

3. a) Regarding your symptoms, which of the following does it affect?

Vision	☐ Yes	☐ No
Speech and hearing	☐ Yes	☐ No
Weakness, paralysis or abnormal sensation	☐ Yes	☐ No
Bowel and bladder	☐ Yes	☐ No

Other, please elaborate:

1. When did you first experience symptoms? (Month/Year)
2. Are these symptoms ongoing? ☐ Yes ☐ No
3. If **Yes**, are they worsening in severity? ☐ Yes ☐ No
4. When did you last experience symptoms? (Month/Year)

4. a) Are your daily activities affected or restricted in any way?

☐ Yes ☐ No

If **Yes**, please provide details:

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AIA Singapore Private Limited (Reg No. 201106386R)
New Business Department,
3 Tampines Grande, #09-01, AIA Tampines, Singapore 528799
AIA Customer Care Hotline: 1800 248 8000 AIA.COM.SG

b) Do you use walking stick or other mobility aid?

☐ Yes ☐ No

If **Yes**, please provide details:

5. Have you been hospitalized or have you undergone any surgery or procedure for this condition?

☐ Yes ☐ No

If **Yes**, please provide details:

Date (Month/Year)	Duration of Stay	Treatment / Procedure	Name of Hospital or Clinic

6. Have you had any of the following tests done?

☐ Yes ☐ No

If **Yes**, please indicate below:

Type of Test	Results	Date (Month/Year)
☐ Blood Test		
☐ CT or MRI scan		
☐ Cerebral angiogram		
☐ EEG		
☐ ECG		
☐ Carotid Ultrasound		
☐ Others, please specify		

7. Have you been prescribed any medication?

☐ Yes ☐ No

If **Yes**, please provide details:

Name of Medication	Date of Commencement	Date of Cessation (If applicable)

8. Do you plan to or have you been advised to undergo surgery or other treatment/investigation in the future?

☐ Yes ☐ No

If **Yes**, please provide details:

Scheduled Date	Type of treatment	Surgery / Investigation

9. a) Are you still on follow up?

☐ Yes ☐ No

If **No**, have you been advised by your doctor that you are no longer required to return for follow ups for your condition?

☐ Yes ☐ No

b) Please provide date of last review. (Month/Year)

10. Please provide names and addresses of all doctors that you have consulted for this condition.

Date / Period of consultation (Month/Year)	Name of doctor	Name & address of clinic or hospital

11. Have you ever taken time off work or your working duties ever been affected or restricted due to this condition?

☐ Yes ☐ No

If **Yes**, please provide details e.g. date and duration of time off

12. Please provide all investigation reports e.g. MRI, CT scan, Cerebral angiogram report, inpatient discharge summary.

☐ 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 disclosure 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.