AIA SINGAPORE
CHOLESTEROL QUESTIONNAIRE

WARNING: In accordance with Section 25(5) of the Insurance Act, as may be amended from time to time, you are to fully and faithfully disclose in this Form all facts which you know, or ought to know, failing which you may receive nothing from the policy and/or the policy issued may be void.

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 was the condition first diagnosed?

2. Please provide the name and address of your main doctor/ clinic consulted for this condition.

3. How often do you see this doctor for this condition (e.g. 2 times per month, every 3 months)?

4. When was your last follow-up consultation?

5. Have you been prescribed any medication? ☐ Yes ☐ No
If yes, please provide details:

Name of Medication	Dosage and Frequency	Date of Commencement	Date of Cessation

6. Have you been hospitalized due to this condition? ☐ Yes ☐ No
If yes, please provide details:

Dates	Symptoms Felt	Treatment / Investigation done and results

7. Please give your most recent lipid profile readings.

Type of Test	Results	Date
Total Chol/HDL Ratio		
Triglyceride		

8. Have you had any of the following tests done? ☐ Yes ☐ No
If yes, please provide details:

Type of Test	Results	Date
☐ Chest X ray		
☐ ECG		
☐ Exercise ECG		
☐ Echocardiogram		
☐ Angiogram		
☐ Nuclear Scan		
☐ Others Please Specify		

Please provide a copy of the test results. ☐ Enclosed ☐ Not available

9. In addition to high cholesterol, do you suffer from any of the following or other conditions not mentioned? ☐ Yes ☐ No
If yes, please tick the followings:

☐ High blood pressure ☐ Brain conditions/ stroke ☐ Kidney conditions/ blood or protein in urine

☐ Heart conditions/ chest pain ☐ Diabetes ☐ others, please specify

10. Please provide any additional information that you feel will be helpful.

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.