AIA SINGAPORE
TUMOURS / CYSTS / LUMPS / GROWTHS QUESTIONNAIRE

Particulars of Insured and Policy Owner

Name of Insured

NRIC/Passport/FIN No.

Name of Policy Owner

NRIC/Passport/FIN No.

Policy Numbers

Questions

1. When was the growth, cyst, lump or tumour first discovered?

2. Where was the growth/tumour located?

3. Please state the precise diagnosis if known, including size of the growth, cyst, lump or tumour.

4. Was the growth described as one of the following:

☐ Malignant/Cancer

☐ Non malignant/Benign

☐ Borderline malignant/Carcinoma in situ

☐ Do not know

5. Has the growth been removed?

☐ Yes ☐ No

If **No**, please state:

a) Have you been advised to undergo any treatment or surgery?

b) Details of Dr's advice, and why removal was not done/required.

c) Details of investigations which have been carried out. Include date(s) and results of tests.

If **Yes**, please provide.

a) Date of removal.

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b) What treatment have you had following the removal (E.g. Tablets, radiotherapy, chemotherapy, etc)?

c) Has there been a recurrence of the growth after it was removed?

6. Please give the names, addresses of all doctors consulted and dates of consultation.

7. Have you been advised to return for any further treatment, surgery, investigation, repeat tests or follow up?

☐ Yes ☐ No

If **Yes**, please provide details and the date of next scheduled appointment.

If **No**, please state date of discharge/date of last follow up.

8. Please provide copies of any medical reports that you may have. E.g. Histology reports, tests, etc. (Kindly provide Letter of Consent if reports are not available)

☐ Enclosed

☐ Not available

9. Remarks - Please provide any additional information that you feel will be helpful in processing your application.

Declaration and Authorisation

I hereby declare and agree that the above particulars and answer are complete and true, and this questionnaire will form part of the contract for the desired insurance on my life. I also authorise AIA Singapore Private Limited to obtain, if necessary, confidential reports from any doctor/clinic/hospital that I have referred above.

Signature of Insured

Date

Signature of Policy Owner
** Applicable if Insured is under age 16*

Date

FSC/IR's Name	FSC/IR's Code	FSC/IR Unit Name	Mobile No.