Manulife

Questionnaire on High Cholesterol

WARNING: STATEMENT PURSUANT TO SECTION 25(5) OF THE INSURANCE ACT (CHAPTER 142): YOU ARE TO DISCLOSE IN RESPECT OF THIS APPLICATION, FULLY AND FAITHFULLY ALL FACTS WHICH YOU KNOW OR OUGHT TO KNOW, OTHERWISE THE POLICY MAY BE VOID.

A. Policy Information

Policy No:

Name of Proposed Life Insured:

NRIC/Passport/FIN/Birth Certificate No:

Name of Owner (if different from Proposed Life Insured):

NRIC/Passport/FIN No:

B. Please answer the following questions with as much details as possible.

1. When were you first diagnosed with high cholesterol?

2. Have you undergone any investigation and/or tests (e.g. ECG, CT scans, blood tests, etc)?

☐ Yes ☐ No

If ***Yes***, please provide details of all the investigations and/or tests:

(a) Type of investigation or test:

(b) Date of each investigation or test:

(c) Result of each investigation or test:

(Please state if result is normal or abnormal. If abnormal, please provide more details.)

3. Please list all the medication(s) and/or treatment(s) that has been prescribed by your doctor.

Please tick accordingly and provide full details:

(a) Medication(s)

(i) Name of medication(s), dosage and frequency:

(ii) Date medication started:

(iii) Are you still on medication:

☐ Yes ☐ No ***(If No, please continue to complete Question iv and v)***

(iv) Were you advised by the doctor to stop medication?

☐ Yes ☐ No

If ***No***, please provide reason to stop medication:

(v) Please provide the date medication is discontinued:

(b) Diet control and exercise

(c) Any other treatment (Please provide details)

(d) No medication or treatment required as advised by doctor

4. Please provide your latest cholesterol levels and attach a copy of the blood test results:

Date of cholesterol test:

Total Cholesterol	:		mg/dL	**OR**	Total Cholesterol	:	mmol/L
HDL Cholesterol	:		mg/dL		HDL Cholesterol	:	mmol/L
LDL Cholesterol	:		mg/dL		LDL Cholesterol	:	mmol/L
Triglycerides	:		mg/dL		Triglycerides	:	mmol/L

5. Please state when was your last medical consultation with your doctor:

6. Please provide the name and address of the doctor(s) and clinic/hospital you have consulted for this condition.

7. Please provide any additional information on your condition which will be relevant in processing your application.

Note: Please submit all investigation test(s) and/or medical report(s), if available.

C. Declaration & Authorisation

1. I / We have read the above statements and answers and they are complete and true to the best of my / our knowledge and belief. I / We understand they will form part of the Application to Manulife (Singapore) Pte. Ltd. for insurance on the above name Life Insured / Joint Owner / Owner.
2. I/We declare that there has been no change in the Proposed Life Insured / Joint Owner / Owner's health conditions, occupation and activity and I / we have received no medical consultation or examination whatsoever, since the date of completion of the Application for the issuance of this Policy.
3. I/We agree to inform Manulife (Singapore) Pte. Ltd. if there is any change in the state of health, occupation or activity of the Insured at any time before the issuance of this Policy.
4. If a material fact is not disclosed in this Application, any policy issued may not be valid. If you are in doubt as to whether a fact is material, you are advised to disclose it. This includes any information that you may have provided to the Financial Adviser Representative / Financial Consultant but was not included in the Application. Please check to ensure you are fully satisfied with the information declared in this Application.

Signature of Proposed Life Insured

Signature of Owner
(If different from Proposed Life Insured)

Date (DD MMM YYYY)

Date (DD MMM YYYY)

If you wish to understand the list of purposes for which your personal data may be used or disclosed, you may refer to the Statement of Personal Data Protection located at our website (www.manulife.com.sg)