

Group Mediwell Classic Individual Health Declaration Form

Important Notice

1. **STATEMENT Pursuant to Section 25(5) of the Insurance Act** (or any subsequent amendments thereof) - We would remind you that you must disclose to us fully and faithfully the facts you know or ought to know otherwise you may not receive any benefits from your Policy.
2. Please note that this insurance is subject to the premium being paid and received in full by the Company within the period specified in the Premium Payment Warranty applied to the Policy in all other instances, failing which there will be no liability under this cover.
3. The liability of the Company does not commence until this Application is accepted and the premium is paid in accordance with clause 2 above.

Intermediary's Name: _____ Intermediary's Code: _____

Group Insurance :	Individual Health Declaration Form (for insured person over age 65 years old)	
A. The Applicant		
Name of Employer _____		
Period of Insurance: From _____ to _____		
B. Particulars of Person to be Insured		
Name of Employee: _____		
Work Permit/ S-Pass.: _____		
Height (m): _____ Weight (kg) _____ Any weight change in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes", how much and why? * Increase / Decrease by _____ kg due to _____		
C. Habits of Person to be Insured		Yes
1. Have you been smoking in the past 12 months? If "Yes", please specify: No. of years smoking _____ No. of cigarette smoke per day _____		<input type="checkbox"/>
2. Do you consume beer, wine or other alcohol? If "Yes", please specify consumption per week. Beer _____ cans (330ml) Wine _____ glasses (100ml) Spirits _____ tots (30ml) Others (please specify type and amount of consumption): _____		<input type="checkbox"/>
3. Have you ever taken any habit forming drugs or been treated for drug addiction?		<input type="checkbox"/>
4. Do you engage in or intend to engage in any sports of hazardous nature (e.g. diving, flying, motor-racing etc.)? If "Yes", please give details: _____		<input type="checkbox"/>
D. Health Declarations You may be required to complete a separate questionnaire for any health conditions declared below.		Yes
1. Have you had any health screening with abnormal results during the last 2 years?		<input type="checkbox"/>
2. Have you ever		
a) had a surgical procedure?		<input type="checkbox"/>
b) been advised to have any diagnostic test, hospital confinement or surgical procedure which has not yet been performed?		<input type="checkbox"/>
c) received any medical advice, counselling or treatment in connection with sexually transmitted disease (e.g. gonorrhoea, syphilis, genital warts/herpes, non-specific urethritis), HIV infection or AIDS?		<input type="checkbox"/>
3. Are you currently undergoing any medical treatment for, ever been treated for, under observation for, or have been told of, any disorder or disease of the following:-		
a) Ears, throat, eyes or other physical disability or condition affecting hearing, speech or sight, otitis media, ear discharge, tonsils, cataracts, glaucoma, detached retina, ear infection?		<input type="checkbox"/>

b) Digestive system, liver, gallbladder, stomach, pancreas, intestines, hepatitis, cirrhosis, stones, hernia, gastritis, ulcer, gastric/intestinal polyp, piles/haemorrhoids, fistula, chronic diarrhoea, irritable bowel disease, rectal bleeding?	<input type="checkbox"/>	<input type="checkbox"/>
c) Respiratory system, chest or breathing discomfort, lung conditions, asthma, bronchitis, pneumonia, persistent cough, tuberculosis, pneumothorax, nasal bleeding, nasal polyps, sinusitis?	<input type="checkbox"/>	<input type="checkbox"/>
d) Heart attack, angina, chest pain, rheumatic fever, murmur, heart valve disorder, irregular or fast heart rate, coronary artery disease, high blood pressure, high cholesterol or any disease or disorder of the heart or the blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>
e) Diabetes, thyroid gland, pituitary gland or any disease or disorder of the endocrine system?	<input type="checkbox"/>	<input type="checkbox"/>
f) Brain, mental or nervous system disorder, fits, epilepsy, paralysis, stroke, weakness of limb, numbness, poliomyelitis, migraine, prolonged headache, loss of balance, dizziness, fainting spells, anxiety or depression?	<input type="checkbox"/>	<input type="checkbox"/>
g) Albumin, protein, blood, sugar or pus in urine, kidney stones, urinary tract infection, prostate problem, incontinence or any disease or disorder of the kidney, bladder or genitourinary system?	<input type="checkbox"/>	<input type="checkbox"/>
h) Gout, arthritis, slipped-disc, persistent back / neck pain, osteoporosis, Systemic Lupus Erythematosus (SLE) or any disease or disorder of the spine, bones, limbs, joints, muscles or connective tissues?	<input type="checkbox"/>	<input type="checkbox"/>
i) Cancer, tumour, cyst or growth of any kind?	<input type="checkbox"/>	<input type="checkbox"/>
j) Anaemia, thalassaemia, haemophilia or any disease or disorder of the blood?	<input type="checkbox"/>	<input type="checkbox"/>
k) Physical defects/deformities, congenital anomalies, premature birth?	<input type="checkbox"/>	<input type="checkbox"/>
l) Skin problem, drug allergy or any other illness, disorder, physical disability or injury not listed above?	<input type="checkbox"/>	<input type="checkbox"/>
m) Any other illnesses not listed above, please give details on separate sheets.	<input type="checkbox"/>	<input type="checkbox"/>
4. During the past five years have you consulted a physician for a general examination or for any reasons not previously noted on this application?	<input type="checkbox"/>	<input type="checkbox"/>

If you answer “Yes” to questions D1 to D4, please provide full details.

Question No.	()	()	()
Nature of Illness / Injury			
Date of Diagnosis / Disability			
Type of Treatment			
Date of Treatment			
Date of last treatment / symptoms / visit to doctor			
Result of Treatment			
Name & Address of Physician / Hospital			

DECLARATION

I/We hereby declare to the best of my/our knowledge and belief that the statements and answers given in this health declaration are true, accurate and complete and that I/We have not withheld any information or material facts that may influence the assessment and acceptance of this insurance. I/We understand that any misstatement of fact, whether by commission or omission may be grounds for Sompo Insurance Singapore Pte. Ltd. ("Sompo") in its absolute and sole discretion to decline to pay any benefit which might otherwise have been payable.

I/We agree that this proposal and declaration shall be the basis of the contract between me/us and Sompo and shall be deemed to be incorporated in such contract. I/We understand that this insurance if accepted will be an annual contract renewable at the discretion of Sompo.

I/We acknowledge and agree (in case of corporate policy, I/we represent that I/we have obtained the consent of the individuals in relation to this policy) that Sompo may collect, use, disclose and/or process my/our personal data (in case of corporate policy, personal data of individuals in relation to this policy) in accordance with the Personal Data Protection Act 2012 for the purposes and uses described in Sompo's Privacy Policy (including the provision of protection, services related to this insurance policy, screening activities in accordance with legal/regulatory obligations/risk management procedures). This may include disclosure to Sompo's business partners, intermediaries, third party service providers and industry associations. Sompo's Privacy Policy can be found at www.sompo.com.sg

I/We consent to receive marketing and promotional information from Sompo (e.g. via email, mail, SMS, etc.). I/We understand that I/we can withdraw or manage my/our consent to receive marketing and promotional information at www.sompo.com.sg

Signature of Employee

Designation:

Date:

Company Stamp and/or Signature of Employer

Name of Authorised Signatory:

Designation:

Date: