



# AIA SINGAPORE ASTHMA/ RESPIRATORY 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

## Questions

1. What was the exact diagnosis?

- Asthma
- Bronchitis
- Pneumonia
- Chronic obstructive pulmonary disease
- Others (please give details)

2. When was the condition first diagnosed?

- Less than 1 year ago
- 1 to 2 years ago
- More than 2 years ago

3. Details of symptoms.

a) How often does Life Assured suffer from symptoms?

- No symptoms in the last 2 years
- Infrequent (symptoms are not on a weekly basis)
- 2-6 days a week
- Daily
- Continuous symptoms throughout the day

b) Days off work/school as a result of this condition in the past 12 months.

- Nil       1-14 days       15 days or more



\*UBY0824\*

4. Have you taken, or have you been advised to take medication or oral steroids for this condition in the last 2 years?

No medication

Inhaler

Oral steroids

Others (please give details)

5. Have you ever been hospitalised for this condition? If yes, please provide all investigation reports eg. Inpatient discharge summary, Chest X-ray, Electrocardiogram etc. If unavailable, please submit the letter of consent.

Yes

No

If yes, please give details.

| No. of times admitted | Date of last admission | Length of stay of last admission |
|-----------------------|------------------------|----------------------------------|
|                       |                        |                                  |

Please enclose a copy of investigation reports.

Enclosed

Not available

6. Please provide the names, address of all doctors consulted, and frequency of visits and period of consultation.

### 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

Signature of Policy Owner

*\* Applicable if Insured is under age 16*

  
Date  
Date

FSC/IR's Name

FSC/IR's Code

FSC/IR Unit Name

Mobile No.

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