general medical questionnaire

UniversalHealth 100

Important Notice:
Statement pursuant to Section 25(5) of The Insurance Act (Cap. 142) (or any subsequent amendments thereof): You are to disclose in this Application Form, fully and faithfully, all the facts which you know or ought to know in respect of the risk that is being proposed; otherwise, the policy issued hereunder may be void. Neither this enrolment form nor the brochure is a contract of insurance. However, your declarations or disclosures shall form the basis of the contract of insurance. The specified terms, conditions and exclusions applicable to this insurance are set out in the policy, a copy of which is available upon request.

Name of Insured Person:

Policy Number:

Medical/health condition concerned:

Date of Birth (dd/mm/yyyy): / / Gender (M/F): Height (cm): Weight (kg):

1. Regarding your symptoms:
   (a) What was the main complaint of the condition?
   (b) When was the condition first diagnosed?
   (c) How frequently did the symptoms occur in the last 12 months? Please provide duration.
   (d) When was the last occurrence of the symptoms?
   (e) In which part of the body was it situated?
2. Have you had any tests or other investigations for this condition? ☐ Yes ☐ No. If Yes, please provide details, including dates or investigations and results. (Please attach copy of medical report(s) with this questionnaire if available.)

3 Final Diagnosis:

4. Treatment (Please tick the appropriate box and specify period of treatment with commencement and completion date)
   ☐ Oral medication – please provide details of medication:
   ☐ Name & Date of Surgery:
   ☐ Physiotherapy or Chiropractic treatment or Chinese medicine practitioner or others:
5. Are you currently receiving any treatment? ☐ Yes ☐ No. If Yes, please give details of treatment:
6. Is regular follow-up required? ☐ Yes ☐ No. If Yes:
   ☐ Any sign of recurrence?
   ☐ Regular follow up:
   State your last follow-up date: Next follow-up date:
7. Is any planned treatment or surgery required? ☐ Yes ☐ No. If Yes, please give details of treatment:

8 Have you lost any time from work? ☐ Yes ☐ No. If Yes, please provide duration and dates.

9. Name and address of your treating Physician and/or Hospital:

10. Have you fully recovered? ☐ Yes ☐ No

I hereby declare that all answers to the foregoing questions are correctly recorded, and that they are full, complete and true.

Signature of the Insured Person
(Signature by Policyholder if the Insured Person is a Minor)

Date

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