

Policy/Certificate no.	
Adviser's/Wakil's no.	
Adviser's/Wakil's name	



**Important note: Pursuant to Section 25(5) of the Insurance Act, you are to disclose in this form, fully and faithfully, all the facts which you know or ought to know otherwise the request effected hereunder may be void.**

**Adult Health Certificate**

**Particulars of policyowner/certificate holder**

Name of policyowner/certificate holder \_\_\_\_\_ NRIC no. \_\_\_\_\_  
 Name of life insured/participant (if differ from above) \_\_\_\_\_ Contact no. \_\_\_\_\_

Application for: <input type="checkbox"/> Revival <input type="checkbox"/> Change of benefit <input type="checkbox"/> Others: Please specify: _____	Payment made with this application _____
--	--

**Information concerning the life insured/participant**

1 (a) How much life insurance (including accident and critical illness or similar Insurance) is in force or pending on your life?	1 (a) Life Accident Critical Illness HSBC Insurance (Singapore) Pte. Limited _____ Others _____		
(b) What is your present height and weight?	(b) Height _____ (cm) Weight _____ (kg)		
(c) Has your weight changed by more than 3kgs (6.6lbs) in the past 6 months?	(c) <input type="checkbox"/> Yes Gain/Loss _____ (kg) <input type="checkbox"/> No		
(d) Are you pregnant? (female only) If yes, were there any complications during pregnancy such as gestational diabetes, hypertension etc? Pls give details.	(d) <input type="checkbox"/> Yes _____ months <input type="checkbox"/> No		
2 Since the date of this policy/certificate, have you:			
(a) Changed your occupation or job? If yes, please specify below the occupation, daily duties and employer's name, address and nature of business.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
(b) Changed your marital status?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
(c) Been declined, postponed or rated up for life and other supplementary insurance, or involved in military activities, private flying, hazardous sports, races or flying other than a fare-paying passenger in a licensed passenger carrying aircraft?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
3 (a) Have you in the last three years resided for more than one month in any other country than your present country of residence?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
(b) Have you ever received any medical advice, counselling or treatment in connection with AIDS, AIDS Related Complex or any other AIDS related condition, been told you had any of these or that you had a positive HIV blood test or in the last 3 months had any of the following symptoms for more than one week continuously: fatigue, weight loss, diarrhoea, enlarged lymph nodes or unusual skin lesions?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
4 (a) Have either your father, mother or any brother or sister suffered or died from heart disease, stroke, high blood pressure, diabetes, kidney disease, breast lump, cancer, paralysis or epilepsy before age 60? If yes, specify whom, age and give full details with dates and diagnoses.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
(b) In the last 12 months, have you smoked cigarettes? If yes, please specify below how many per day.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
5 Have you ever suffered from or been treated or investigated for the following:			
(a) Heart disease, stroke, high blood pressure, diabetes, kidney disease, cancer, paralysis, epilepsy or multiple sclerosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
(b) Sugar in the urine, rheumatic fever, lung disease, ulcer, disorder of the digestive tract, mental or nervous disorder, or any other disease, disorder, defect or injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
(c) Disorders of the breast, irregular or painful or unusually heavy menstruation, fibroids, cysts, or any other disorders of female organ? (Female only)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
(d) Abnormal papsmear test or been told to repeat papsmear within the next 6 months? (Female only)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
6 Since application date of the above policy/certificate, have you (a) been ill, (b) consulted any doctor for any reason, (c) been treated or been advised to take treatment, or (d) been absent from work for more than one week on any occasion due to sickness or accident? If yes, please give details below on the date, duration and nature of sickness or accident, the nature and results of any tests done or advised and the name and the address of physician or hospital.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Date and duration	Diagnosis, symptoms, nature of sickness or accident	Nature and results of any tests done or advised	Name and address of physician or hospital and if appropriate period of hospitalisation
7 If any of the answers to question 2 through 6 is 'Yes', please give dates and details, including names of insurance company if appropriate. (Please quote the question no.)			

**Declaration and authorisation**  
 I confirm that the above answers, given by me are full, complete, true and agree that they form part of any policy/certificate issued, revived or amended, where these answers are, or may be, relied upon by the Company. I further agree that such revival, change or addition shall not be considered as effected by reason of any money paid or settlement made in payment of or on account of any premium/contribution, until this policy/certificate shall be duly approved by an authorized officer of the Company. I further agree that if my application for any revival, change or addition be accepted by the Company, the Incontestability and Suicide Provisions thereof shall have effect from the approval date of my application for revival, change or addition.  
 I further authorise any physician, hospital, clinic or insurance company or other organisations, institutions or persons, that has any records or knowledge of me or my health, to disclose to HSBC Insurance (Singapore) Pte. Limited or its representatives any and all such information and expressly waive on behalf of myself or any person, who shall have or claim any interest, in any policy/certificate issued hereunder, all provisions of law forbidding any physician or surgeon from disclosing any information acquired while attending me in a professional capacity.  
 This authorisation shall irrevocably bind my successor and assigns and remain valid, notwithstanding my death or incapacity and a copy of this authorisation shall be as effective and valid as the original.  
 Dated this \_\_\_\_\_ day at \_\_\_\_\_ 20 \_\_\_\_  
 \_\_\_\_\_  
 Signature of life insured/participant Name: \_\_\_\_\_ NRIC no: \_\_\_\_\_  
 Signature of policyowner/certificate holder (If differ from life insured/participant) Name: \_\_\_\_\_ NRIC no: \_\_\_\_\_

Note: We will advise you if a medical examination is required under Company's rules.