

**HSBC Insurance (Singapore) Pte. Limited**

10 Eunos Road 8, #11-01 Singapore Post Centre, Singapore 408600 Tel: (65) 6225 6111 Fax: (65) 6221 2188 Web site: [www.insurance.hsbc.com.sg](http://www.insurance.hsbc.com.sg)  
Company registration no. 195400150N

## Group Insurance Health Declaration Form

**Statement pursuant to Section 25(5) of the insurance act (cap 142), you are to disclose in this proposal form, fully and faithfully, all the facts which you know or ought to know. Otherwise, the policy issued hereunder may be void.**

**Please complete in block letters and ink. Any alteration must be initialed.**

Employer		Person-in-charge		Tel (office)		Fax (office)		
Name of person to be insured (as in NRIC, underline surname)								
Date of birth		NRIC/passport no.		Nationality		Citizenship		
Sex		Race		Marital status				
Occupation & job duties			Date of hire		Monthly salary		Email address (if any)	
Address of person to be insured				Postcode		Tel (home)		
Height (cm)		Weight (kg)		Any weight change over the past year? Amount of weight change:		<input type="checkbox"/> Yes <input type="checkbox"/> No Reasons:		

**Note:** If the master policy provides coverages for dependants, please also complete those questions for spouse/children. If not, to ignore.

Spouse to be insured		Sex		Date of birth		NRIC/passport no.		Height (cm)		Weight (kg)	
First child to be insured		Sex		Date of birth		NRIC/passport no.		Height (cm)		Weight (kg)	
Second child to be insured		Sex		Date of birth		NRIC/passport no.		Height (cm)		Weight (kg)	

(Please tick answers accordingly)

**Family health history**

1. Has either of the insured's natural parents or any siblings suffered or died from heart disease, stroke, high blood pressure, diabetes, kidney disease, cancer (please specify type), paralysis, epilepsy, mental illness or has the insured's spouse suffered from any AIDS related condition?  Yes  No If yes, give full details below.

Living		Deceased	
Relationship		Age at onset of illness	
Suffering from		Age at death	
		Cause of death	

**Personal health history**

2. Has the insured ever had any application for life, accident or health insurance rejected, postponed or accepted at other than standard terms by any insurer?
3. a) Does the insured smoke cigarettes?  
If yes, how many sticks per day:  & for how long   
b) Has the insured smoked any cigarettes in the past 12 months?
4. Has the insured taken drugs before or does the insured consume alcohol?  
If yes, state type  and quantity consumed:
5. Does the insured engage in any hazardous activities, sports or pastimes? Details:
6. Has the insured ever suffered or do the insured now suffer from heart disorder, high blood pressure, chest pains, renal stones, kidney disease, diabetes, asthma, blood disorder, liver disease, hepatitis, cancer, growths or other malignancies, mental disorder, HIV infection or any other serious illnesses/physical disabilities?
7. Has the insured ever suffered or does the insured now suffer from any disorders or any other diseases, deformities or complaints which have not been mentioned above?
8. Has the insured received any medical advice, counselling or treatment in connection with AIDS, AIDS related complex or any other AIDS related condition, been told the insured had any of these or that the insured had a positive HIV blood test or in the last three (3) months had any of the following symptoms for more than a week continuously: fatigue, weight loss, diarrhoea, enlarged lymph nodes or unusual skin lesions?
9. Is the insured currently under observation or receiving any treatment or medication?
10. Does the insured intend to seek medical treatment in the near future?
11. In the past five (5) years, has the insured had any diagnostic test such as X-ray, electrocardiogram or blood study, illness, operation, medical advice, hospital treatment not mentioned above?
12. Female: is the insured pregnant? If so, how many months:
13. Female: has the insured ever had any complication at childbirth or disorder of the breast or female organs?

Applicant	Spouse	Children
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**If the insured answer "Yes" to any of the questions above, please provide full details. Please attach a complete set of medical reports if the insured has any.**

Nature of illness/disease		Commencement date		Duration		Present condition (ie. type of medication, treatment received, date of last consultation, etc.)		Name and address of doctor	

I declare that the above answers are true and correct to the best of my knowledge and that I have not withheld any relevant information which might have otherwise affected the acceptance of my application. Otherwise the policy may be void from inception. I also authorise any medical body or insurance company or the Life Insurance Association's (LIA) medical register that has knowledge about me to disclose to HSBC Insurance (Singapore) Pte. Limited or for HSBC Insurance (Singapore) Pte. Limited to release to any medical source, insurance office or the LIA's medical register any relevant information concerning me at any time, irrespective of whether the proposal is accepted by the company. I understand and agree that the insurance applied for will become effective only upon acceptance by the company and the premium being fully paid. A photocopy of this authorisation shall be as valid as the original.

Signature of person to be insured		Date		Signature of spouse to be insured		Date	

GTL sum insured	GDII sum insured	CIB sum insured	GPA sum insured	GHS plan

**For official use**

Policy no.	Member no.	Age next birthday:	Sex: F <input type="checkbox"/> / M <input type="checkbox"/>
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**Underwriting for:**

	Free cover limit	Last sum insured	Excess sum insured	<b>Total sum insured</b>
<b>GTL/TPD</b>				
<b>GDII</b>				
<b>CIB+</b>				
<b>GHS plan</b>				

**Checklist to be completed by servicing staff:**

<input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Children <input type="checkbox"/> HDF duly completed including height/weight <input type="checkbox"/> Height/weight: Std / Ow / Uw	<input type="checkbox"/> New case <input type="checkbox"/> Existing case, to attach previous u/w papers <input type="checkbox"/> U/W requirements: (HIV required for SI \$500,000 & above)
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**Underwriter's decision:**