



**Option Conversion Underwriting Form**

**IMPORTANT NOTE:** Before you complete this form, you should seek advice from your adviser. This form must be submitted with the Personal Financial Review (PFR) duly signed by your adviser and yourself.

**Warning:** 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 conversion effected hereunder may be void.

Only original form correctly completed is considered a valid request and it is irrevocable by the policyowner. The request will not take effect until approved by the company.

Policy no.	
Adviser's no.	
Adviser's name	

Name of policyowner:	NRIC no. :	Contact no.:
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Option Conversion		
<input type="checkbox"/> Option 1 to Option 2	<input type="checkbox"/> Option 1 to Option 3	<input type="checkbox"/> Option 2 to Option 3
Note: For other option conversion, use Request for Amendment Form.		

**Health Questions and Others**

**1. Family health history**

Have either of your natural parents or any siblings suffered or died from heart disease, stroke, high blood pressure, diabetes, kidney disease, cancer (pls specify type), paralysis, epilepsy, mental illness, tuberculosis or any hereditary disease? If yes, give full details below.  Yes  No

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

**2. Health details and habits**

1) Life insured: Height (cm) _____ Weight (kg) _____				
Policyowner: Height (cm) _____ Weight (kg) _____				
	Life insured	Policyowner	Yes	No
2) Has any application for or reinstatement of your life or accident insurance ever been declined, postponed, rated or modified in any way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) a. Do you smoke cigarettes? If yes, how many sticks per day? _____ for how many years? _____ yrs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you smoked any cigarettes in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) Do you take drugs? If yes, state type and quantity consumed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) Do you take alcohol? If yes, state type and quantity consumed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) Are you now a member of any military force, do you contemplate engaging in any private flying, diving, sky diving, rock/mountain climbing, racing or any other hazardous sports or flying other than as a fare paying passenger on a regular scheduled airline or have you in the last five years engaged in such flying or sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7) Give name and contact no. of your usual doctor:				
Life insured:				
Policyowner:				
8) State date and nature of your last consultation and give name and address of the doctor consulted.				
Life insured:				
Policyowner:				

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**3. Health questions**

	Life insured		Policyowner	
	Yes	No	Yes	No
1) Have you ever had or been told to have or been treated for:				
a. epilepsy, fits, stroke, paralysis, weakness of limb, prolonged headache, unconsciousness, nervous breakdown, depression or any other nervous/mental, disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. diabetes, thyroid disorders or any other endocrine disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. ear discharge, nose bleeds, double vision, impaired sight, hearing or speech or any other disorders of ear, eye, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. asthma, persistent cough, coughing with blood, pneumonia, tuberculosis, chest or breathing complaints/discomfort or any other lung disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. raised cholesterol, high blood pressure, heart attack, heart murmur, mitral valve prolapse or other heart valve disorders, breathlessness, irregular or fast heart rate, chest discomfort or pain, disease of or any other disorders of the heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. gastritis, stomach or duodenal ulcer, blood in stools, fistula, piles or any other stomach or bowel disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. jaundice, hepatitis B carrier or any form of hepatitis, liver disorder or gall bladder disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. blood, protein or sugar in urine, kidney stones, infection or any other disorders of the kidney, bladder or genital organs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. slipped disc, gout, arthritis, pain or deformity or disorders of the muscles, spine, limbs or joints or severe injury?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. cancer, tumours, cyst or growths of any kind?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. anaemia, any other disorders of the blood, advised to abstain from donating blood or received blood transfusion or blood products on account of haemophilia or any other reason?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. any other illness, disorder, operation, physical disability or accident not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) Have you or your spouse been told to have, received any medical advice, counselling or treatment in connection with sexually transmitted disease, AIDS, AIDS related complex or any other AIDS related condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) Have you ever had HIV testing done (please state reason and results); or in the last three months had any of the following symptoms for more than one week continuously: fatigue, weight loss, diarrhoea, enlarged nodes or unusual skin lesions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) Have you gone abroad other than for holidays during the last two years? If yes, please provide full details: purpose, destination, length of stay and frequency (per annum).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) In the past five years, have you had any tests done such as X-ray, ultrasound, CT scan, biopsy, electrocardiogram (ECG), blood or urine test?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) Female (only)				
a. Have you suffered from or are you aware of any breast lumps or any other disorders of your breasts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you suffered from irregular or painful or unusually heavy menstruation, fibroids, cysts or any other disorders of female organs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Have you ever had any abnormal pap smear test or been told by any doctor to have a repeat pap smear within the next six months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Have you been advised to have a mammogram, biopsy, operation of the breasts, ultrasound of the pelvis or any other gynaecological investigation? If yes, please state type, reason, date of test done and results of test (copy to be submitted if available).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. For females who have conceived, were there any complications during pregnancy such as gestational diabetes, hypertension, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Are you now pregnant? If yes, how many months? _____ month(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7) <b>If any of the answers to section 2 and 3 is "Yes", give full particulars below, including nature of diseases or illness, relevant dates, duration, name and address of doctors, place of treatment and present condition, noting the question number:</b>				
Life insured:				
Policyowner:				

\_\_\_\_\_  
Signature of life insured

\_\_\_\_\_  
Signature of policyowner /trustee/assignee

\_\_\_\_\_  
Date(dd/mm/yy)

For Takaful policy, please read "certificate" for policy, "certificate holder" for policyowner, "wakil" for adviser, "participant" for life insured, "takaful benefit" for sum insured.