

**HSBC Insurance (Singapore) Pte. Limited.** (Reg. No. 195400150N)  
21 Collyer Quay #02-01 Singapore 049320, Monday to Friday 9.30am to 5pm. [www.insurance.hsbc.com.sg](http://www.insurance.hsbc.com.sg).  
Customer Care Hotline: (65) 6225 6111 Fax: (65) 6221 2188  
Mailing address: Robinson Road Post Office P.O. BOX 1538 Singapore 903038.

## History of Illness Questionnaire

**WARNING:** Statement 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.

Proposal no : \_\_\_\_\_  
Name of life insured/participant : \_\_\_\_\_  
Name of policyowner/certificate holder : \_\_\_\_\_  
(if other than life insured/participant)

1. What was the diagnosis and underlying cause told by the doctor?

\_\_\_\_\_

2. When was the illness first diagnosed?

\_\_\_\_\_

3. Please describe the signs and symptoms experienced during your illness.  
Please state the date of first symptoms, the frequency of symptoms in a year and date of last symptoms.

\_\_\_\_\_

4. Have there been any tests or investigations carried out? Yes \_\_\_ No \_\_\_  
(e.g. Blood Test, Urine test, MRI, X ray, CT-scan, etc)?  
If "Yes", please state the date, results and submit copies of the investigations report, if any.

\_\_\_\_\_

5. Are you currently or previously on any treatment/medication? Yes \_\_\_ No \_\_\_  
If "Yes", please provide name of medication, dosage, frequency and date last taken.

\_\_\_\_\_

6. Have you ever been hospitalised due to this condition? Yes \_\_\_ No \_\_\_  
If "Yes", please state the date of admission, duration of stay and full name of hospital.

\_\_\_\_\_

7. Have you ever been recommended for surgery? Yes \_\_\_ No \_\_\_  
If "Yes", please state date of surgery done or planned.

\_\_\_\_\_

8. Was there any recurrence of the illness? Yes \_\_\_\_ No \_\_\_\_  
If "Yes", please provide date of last episode and the frequency.

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9. Are there any complications or functional capacity limitations including ability to work or lifestyle? Yes \_\_\_\_ No \_\_\_\_  
If "Yes", to what extent has it limits your occupational or lifestyle activities.

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10. Are you currently or previously on any follow up? Yes \_\_\_\_ No \_\_\_\_  
If "Yes", please state date of last consultation and/or next appointment.

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11. Have you fully recovered from this condition? Yes \_\_\_\_ No \_\_\_\_  
If "Yes", please state date of recovery.

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12. Please provide full name and address of doctor whom you have consulted for this condition.

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I declare that to the best of my knowledge and belief, the information given by me is true and complete and that no material facts (i.e. facts likely to influence the assessment and acceptance of my proposal for the life insurance) have been withheld.

I agree that this form shall constitute a part of my proposal for Life Insurance with HSBC Insurance (Singapore) Pte. Limited.

\_\_\_\_\_  
Signature of life insured/participant

\_\_\_\_\_  
Signature of policyowner/certificate holder  
(if other than life insured/participant)

Date: \_\_\_\_\_

Date: \_\_\_\_\_