

IF YOU ANSWERED “YES” TO ANY QUESTIONS 2, 3, 4 IN C-SECTION IN HEALTHCARE INSURANCE APPLICATION, PLEASE PROVIDE BELOW DETAILS

Question No.: _____

1. The first symptom(s) appear (or Accidents/Injuries occur): (dd/mm/yyyy)

2. Symptom(s)’s description:.....

3. Part(s) of body affected (please state right/left):.....

4. The underlying cause (or Type of Accidents/Injuries):.....

5. The exact diagnosis made by doctor:.....

6. Treatment:

Medication. Name and dosage:

Tests/ Radiology. Name and result:

Surgery. Please state the details (when, number and type of each surgery, etc.).....

Pin/Material inserted into the body? No Yes, when it removed (day/month/year)

Others. Please state the details:

7. Frequency of attacks in the past 12 months (for illness only):

8. Date of last consultation (day/month/year):

9. Current status:

Full recovery.

Not completely recovery. Please state the details, current treatment and ongoing treatment:.....

10. Name and address of treating doctor/clinic/hospital:.....

11. (*) For Hypertension, Dyslipidemia, Abnormal Glycemia. Please provide these indexes taken within the last 03 months:

Blood pressure: The highest:..... The last 03 months:

Lipid profiles: Cholesterol:..... HDL:LDL: **Triglycerides:**.....

Fasting plasma glucose:HbA1c:

12. Any additional information (if have) which is not indicated above:.....

13. Please provide all related medical report (if available).

If the space provided is insufficient, please use back of page.

Signature of Insured Person:.....

Name of Insured Person:..... Date (dd/mm/yyyy):

(**) If the Insured Person provides “General Questionnaire” by their email which is registered in Healthcare Insurance Application Form, the “Signature of Insured Person” can be ignored; the information of “Name of Insured Person” and “Date” still need to be provided.

