

GENERAL QUESTIONNAIRE

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

Question No.: _____

1. Time of the first symptom(s) appearance (or Accidents/Injuries occur) (dd/mm/yyyy):

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

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

4. The exact diagnosis made by doctor:

5. 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:

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

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

8. Current status:

☐ Full recovery.

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

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

10. (*) 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:

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

12. 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/yy):

(**) 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.

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