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| **Financial Consultant** ( if applicable )Name of Financial Consultant : Name of Company ( if applicable ) : RHI Code :  | ***For Official Use Only***Policy Number :  |

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| **PERSONAL HEALTH DECLARATION FORM** |

**Important Note: Pursuant to Section 25(5) of the Insurance Act (Cap. 142), you are to disclose in this form, fully and faithfully,**

 **all facts which you ought to know, otherwise, nothing may be payable under the policy.**

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| **A) PARTICULARS OF PROPOSED STUDENT / ELIGIBLE MEMBER** |
| Name (as shown in NRIC/ FIN) Dr [ ]  Mr [ ]  Mrs [ ]  Miss [ ]    | NRIC/ FIN No.  | Date of Birth (dd/mm/yy)   | Age Next Birthday  |
| GenderMale [ ]  Female [ ]  | Marital StatusSingle [ ]  Married [ ]  Divorced [ ]   | Nationality  | Height (m)   | Weight (kg)   |
| Name and Address of School  |
| Matriculation No.  | Date of Matriculation (dd/mm/yy)  |

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| **B) FAMILY HISTORY OF PROPOSED STUDENT / ELIGIBLE MEMBER** |
| Has any of your parents or siblings died or suffered from cancer (specify type), heart diease, stroke, high blood pressure, diabetes, kidney disease, mental disorder, tuberculosis or any hereditary disease(s)? Yes [ ]  No [ ]   (If yes, please provide details below) |
| If Alive | If Deceased |
| Relationship(Father, mother, sister or brother) | Please indicate type of Medical Condition and the exact Diagnosis | Age at time of Diagnosis | Age at Death | Cause of Death |
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| **C) DEPENDENT(S) PARTICULARS – Complete this section only if you are applying insurance for your dependents.** |
| Relationship | Name (as shown in NRIC/ FIN) | NRIC/ FIN | Sex | Date of Birth | Height(m) | Weight(kg) |
| Day | Month | Year |
| Spouse |   |   |   |   |   |   |   |   |
| Child 1 |   |   |   |   |   |   |   |   |
| Child 2 |   |   |   |   |   |   |   |   |
| Child 3 |   |   |   |   |   |   |   |   |

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| **D) Habits of Proposed Student / Eligible Member** |
| Please tick Yes or No. If Yes, please provide details in the space provided. |  | ***Please Complete Where Applicable*** |
| Student | Spouse | Child 1 | Child 2 | Child 3 |
| Yes or No | Yes or No | Yes or No | Yes or No | Yes or No |
| 1. Have you ever smoked in the last 12 months?

If Yes, please provide details of smoking:* 1. No. of sticks you smoke per day:
	2. No. of years since you have been smoking:
 | [ ] [ ] **\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_** | [ ] [ ] **\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_** | [ ] [ ] **\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_** | [ ] [ ] **\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_** | [ ] [ ] **\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_** |
| 1. Do you consume beer, wine or other alcoholic beverages?

If Yes, please provide details of alcohol consumption:* 1. Type of alcohol taken:
	2. Average weekly consumption with units of measurement:
 | [ ] [ ] **\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_** | [ ] [ ] **\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_** | [ ] [ ] **\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_** | [ ] [ ] **\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_** | [ ] [ ] **\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_** |
| 1. Do you engage in or intend to engage in any sport(s) or occupation of a dangerous / hazardous nature? E.g. scuba / skin diving, motor racing, military / private flying other than as a fare paying passenger, parachuting, etc?

If Yes, please state details on the type of sports you participate in: | [ ] [ ] **\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_** | [ ] [ ] **\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_** | [ ] [ ] **\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_** | [ ] [ ] **\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_** | [ ] [ ] **\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_** |
| **E) Particulars Of Health Of Proposed Student / Eligible Member**  |
| Please tick Yes or No. If Yes, please provide details under Section F. |  | ***Please Complete Where Applicable*** |
| Student | Spouse | Child 1 | Child 2 | Child 3 |
| Yes or No | Yes or No | Yes or No | Yes or No | Yes or No |
| 1. Has any proposal for life or disability or health assurance on your life to this or any other insurance office ever been declined, postponed or accepted at other than normal terms?
 | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  |
| 2 Are you now receiving or considering to receive medical treatment from a doctor or intending to consult any doctor for any reason? | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  |
| 3 Have you ever undergone any health screening or had any medical investigations carried out, whether on your own accord or on the recommendation of a doctor, such as X-ray, ultrasound, electrocardiogram (ECG), barium meal examination, CT scan, biopsy, blood or urine test, etc., in the past 5 years? | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  |
| 1. Have you ever taken drugs, narcotics, glue sniffing or been treated for drug addiction?
 | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  |
| 1. Have you ever had or been treated for alcoholism?
 | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  |
| 1. Have you ever had or been told to have or been treated for:
	1. Diabetes, thyroid disorders, or any other endocrine disorders?
 | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  |
| * 1. Asthma, persistent cough, coughing with blood, pneumonia, tuberculosis, bronchitis, chest or breathing complaints or discomfort, and/or any other lung disorders?
 | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  |
| * 1. Raised cholesterol, high blood pressure, heart attack, rheumatic fever, Kawasaki disease, heart murmur, palpitation, coronary artery disease, mitral valve prolapse, or other heart valve disorders, breathlessness, irregular or fast heart rate, chest discomfort or chest pain, and/or any disease or disorders of the heart of blood vessels?
 | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  |
| * 1. Epilepsy, fits, stroke, paralysis, dementia, Parkinson’s disease, multiple sclerosis, motor neurone disease, weakness of limbs, polio, fainting spells, prolonged headache, unconsciousness, nervous breakdown, depression, or any other nervous or mental disorders, or disease of the brain?
 | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  |
| * 1. Gastritis, stomach or duodenal ulcer, blood in the stools, fistula, hernia, haemorrhoids or piles, irritable bowel syndrome, or any other stomach or bowel disorders?
 | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  |
| * 1. Jaundice, hepatitis B carrier or any form of hepatitis, liver disorder or gall bladder disorder?
 | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  |
| * 1. Albumin or protein in urine, blood or sugar in urine, kidney stones, infection or any other disorders of the kidney, bladder, urinary or genital organs?
 | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  |
| * 1. Slipped disc, gout, any form of arthritis, joint pain or deformity, and/or disorders of the muscles, spine, limbs or joints or severe injury?
 | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  |

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| **E) Particulars Of Health Of Proposed Student / Eligible Member (continued)** |
| Please tick Yes or No. If Yes, please provide details under Section F. |  | ***Please Complete Where Applicable*** |
| Student | Spouse | Child 1 | Child 2 | Child 3 |
| Yes or No | Yes or No | Yes or No | Yes or No | Yes or No |
| i. 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? | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  |
| j. Ear discharge, nose bleeds, double vision, or visual impairment or impaired hearing or speech, or any other disorders of the ear, nose or throat? | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  |
| * 1. Cancer, tumours, cysts or growths of any kind?
 | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  |
| * 1. Congenital anomalies, physical disability or any unusual skin lesions, or any other illness, disorder, operation, hospital admission, accident or injury not mentioned above?
 | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  |
| 1. Have you or your spouse been told to have, or received any medical advice or counselling or treatment in connection with sexually transmitted disease, AIDS, or AIDS Related Complex or any other AIDS related condition?
 | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  |
| 1. a) Have you ever had HIV testing done?

b) Have you ever in the last 3 months had any of the following symptoms for more than one week continuously: fatigue, weight loss, diarrhoea, enlarged nodes or unusual skin lesions? | [ ] [ ] [ ] [ ]  | [ ] [ ] [ ] [ ]  | [ ] [ ] [ ] [ ]  | [ ] [ ] [ ] [ ]  | [ ] [ ] [ ] [ ]  |
| 1. Do you have a regular attending doctor?

If Yes, please state the name of doctor and the address of clinic  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  | [ ] [ ]  |
| 1. **FOR FEMALE ONLY** (Also to be completed for child(ren) aged 12 years and above)
	1. Have you ever been found to have or are you aware of any breast lumps or any other disease or disorders of the breast?
	2. Have you ever suffered from irregular or painful or unusually heavy menstruation, fibroids, cysts or any disorders of the female organs?
	3. Have you ever had any abnormal pap smear test or been told by any doctor to have a repeat pap smear within the six months?
	4. Have you been advised to have mammogram, biopsy, operation of the breasts, and ultrasound of the pelvis or any other gynaecological investigations?
	5. Were there any complications during any of your pregnancy such as gestational diabetes, hypertension, etc.?
	6. Are you pregnant now?

 If Yes, please state the weeks / months of pregnancy. | [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  [ ] [ ]  [ ] [ ]  | [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  | [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  [ ] [ ]  | [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  | [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  |

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| **F) If the answer to any questions in Section E is Yes, please provide FULL DETAILS.** (If there is sufficient space below, kindly use a separate page and attach to this application form) |
| Question Number | Name of Person Concerned (Student/Spouse/Child(ren) | Details of Diagnostic Test with reason & result / Doctor’s Diagnosis / Injury / Treatment | Duration of Illness | Name of Doctor Consulted & Address of Clinic |
| From  | To |
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| **G) PERSONAL DATA PROTECTION NOTIFICATION** |
| I/ We acknowledge that:

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| 1) To process, administer and/or manage My/Our relationship, account and policy with Raffles Health Insurance Pte. Ltd., You will necessarily need to collect, use, disclose and/or process My/Our personal data or personal information about Me/Us. Such personal data includes: (i) information set out in this proposal/ application form and any other personal information provided by Me/Us or possessed by Raffles Health Insurance Pte. Ltd. and (ii) my/our claims. 2) Such personal data will be collected, used, disclosed and/or processed by Raffles Health Insurance Pte. Ltd. for the purpose(s) of : (a) considering whether to provide Me/Us with the insurance I/We applied for; (b) processing My/Our application for underwriting and insurance; (c) Administering and/or managing My/Our relationship, account and/or policy with Raffles Health Insurance Pte. Ltd.; (d) processing and/or dealing with any claims including the settlement of claims and any necessary investigations relating to the claims, under My/Our policy; (e) Carrying out due diligence or other screening activities (including background checks) in accordance with legal or regulatory obligations or risk management procedures that may be required by law or that may have been put in place by Raffles Health Insurance Pte. Ltd.; (f) Carrying out My/Our instructions or responding to any enquiries by Me/Us; (g) Dealing in any matters relating to the services and/or products which I/We are entitled to under this policy which I/We are applying for or have applied; (including the mailing of correspondence, statements, invoices, reports or notices to Me/Us, which could involve disclosure of certain personal data about Me/Us to bring about delivery of the same as well as on the external cover of envelopes/mail packages); (h) Investigating fraud, misconduct, any unlawful action or omission, whether relating to My/Our application, My/Our claims or any other matter relating to My/Our policy, and whether or not there is any suspicion of the aforementioned; and/or  |
| (i) Complying with applicable law in administering and managing My/Our relationship with Raffles Health Insurance Pte. Ltd. (j) **sending me marketing, advertising and promotional information about other insurance, investment and/or financial products and/or services that**  **Raffles Health Insurance Pte. Ltd. may be selling or marketing, and which Raffles Health Insurance Pte. Ltd. believes may be of interest or benefit to**  **me, by the following modes of communication:** * **postal mail, electronic transmission to my email address, SMS/MMS (text message) and fax;**

[ ]  **Please tick this box if you do not wish to receive communication via postal mail, email, SMS/MMS (text message) and fax.*** **to my telephone number(s):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **by way of :**

 [ ]  **voice call (Please tick this box if you do not wish to receive communication via voice calls)** |

(Collectively the “**Purposes**”)3) Raffles Health Insurance Pte. Ltd. may/will also be collecting from sources other than Myself/Ourselves, personal data about Me/Us, for one or more of the  above Purposes, and thereafter using, disclosing and/or processing such personal data for one or more of the above Purposes.4) My/Our personal data may/will be disclosed by Raffles Health Insurance Pte. Ltd. to its reinsurers, third party service providers or agents (including its lawyers / law firms), which may be sited outside of Singapore, for one or more of the above Purposes, as such third party service providers or agents, if engaged by Raffles Health Insurance Pte. Ltd, would be processing My/Our personal data for Raffles Health Insurance Pte. Ltd. for one or more of the above Purposes.5) By signing on this proposal or application form, I/We consent to Raffles Health Insurance Pte. Ltd in:(a) collecting, using, disclosing and/or processing My/Our personal data for the Purposes as described above;(b) collecting personal data about Me/Us from sources other than Myself/Ourselves and using, disclosing and/or processing the same, for one or more of the Purposes as described above;(c) disclosing My/Our personal data to its third party service providers, or agents (including its lawyers / law firms), for the Purposes as described above; and(d) transferring My/Our personal data out of Singapore to its third party service providers, or agents where such third party service providers or agents are sited (whether in Singapore or outside of Singapore), for the Purposes as described above.(e) representing and warrant that My/Our personal data provided in this form, for the purpose as described above and have read and understood the above provisions.**Important Note:** Individuals aged 16 and above are required to provide consent for the collection, use, and disclosure of their personal information. |

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| **H) DECLARATION AND AUTHORISATION** |
| I/We hereby declare that to the best knowledge and belief the statements and answers given in this health declaration are true, complete and that I/We have not withheld any material facts, that is, facts likely to influence the assessment and acceptance of this application. I/We understand that any misstatement of fact, whether by commission or omission may be grounds for the Company in its absolute and sole discretion to decline to pay any benefit for myself and/or my Dependant(s) which may otherwise have been payable. I/We agree that this application, together with any additional statements signed by myself and/or my Dependant(s) which shall be deemed to be part of this declaration, shall be the basis of the contract of the insurance.I/We understand that my application will be subject to acceptance by the Company, and that I and/or my Dependant(s) will not be insured under any of the insurance plan(s) for which I and/or my Dependant(s) are subject to acceptance until the Company advises the Policyholder the terms and conditions on accepting insurance on myself and/or Dependant(s), and that the Company reserves the right to decline insurance or impose special terms and conditions.I/We understand that:

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| 1. If my application for myself and/or my Dependant(s)’ insurance under any of the above plan(s) is accepted, myself and/or my Dependant(s)’ insurance under the plan shall terminate if the Policyholder does not renew the plan upon expiry of any period of insurance, or cancel the plan, or if I and/or my Dependant(s) attain the age at which I and/or my Dependant(s)’ insurance terminates as specified in the terms and conditions of the insurance plan, and

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| 1. These plan(s) are yearly renewable and that the terms and conditions of the insurance plan(s) I and/or Dependant(s) are insured under, including the premium payable, at any renewal of the plan(s), may change upon agreement between the Policyholder and the Company.
 |

I/We hereby authorize any hospital, medical practitioner, clinic or other medical related facility, insurance company or other organizations or persons to release to you any information concerning my/our medical condition or history or knowledge of me and/or my Dependant(s) to the Company for risk assessment of my Group Insurance Application. I/We further consent to the Company in releasing any information declared in my and/or my Dependant(s)’ Personal Health Declaration Form / Personal Statement and/or information revealed in my and/or my Dependant(s)’ questionnaires, medical reports and laboratory reports to my employer or the administrator and/or the appointed insurance intermediary servicing this Group Insurance Policy. A photocopy of this authorisation shall be as effective and valid as the original.**WARNING**: If a material fact is not disclosed in this proposal, any policy issued may not be valid. If you are in doubt as to whether a fact is material, you are advised to disclose it. This includes any information that you may have provided to the insurance advisor/agent but was not included in the proposal. Please check to ensure that you are fully satisfied with the information declared in this proposal. |

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| **SIGNED IN SINGAPORE ON: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(DAY)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(MONTH) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(YEAR)** |

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| **Name & Signature of Proposed Student :**  |

**Note: Dependents aged 16 and above are required to sign**

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| **Name & Signature of Dependent – Spouse:**  |
| **Name & Signature of Dependent – Child 1:**   |
| **Name & Signature of Dependent – Child 2:**   |
| **Name & Signature of Dependent – Child 3:**   |

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Raffles Health Insurance Pte Ltd

(Registration No. 200413569G)

Corporate Office: 585 North Bridge Road #11-00 Raffles Hospital Singapore 188770

Correspondence Address: 25 Tannery Lane Singapore 347786 | Tel: 68126500 Fax: 68126615 | Website: [www.raffleshealthinsurance.com](http://www.raffleshealthinsurance.com)