income made different

NTUC Income Insurance Co-operative Limited
Income Centre 75 Bras Basah Road Singapore 189557
Website: www.income.com.sg · Fax: 6338 1500
an NTUC Social Enterprise

Product Type
☐ Affinity ☐ ElderShield
☐ DPS ☐ IncomeShield
☐ Employee Benefit ☐ Life Insurance

Mental health questionnaire

If you have any questions on Life Insurance, please contact us at 6788 1122 or csquery@income.com.sg
For questions on other product type, you may contact us at 6332 1133 or healthcare@income.com.sg

Details of insured

Name (as shown in NRIC or FIN)	NRIC number or FIN	Proposal number(s)

Questions for insured

1 Description

a) What symptoms did you experience?

Description of symptoms	
Date of first occurrence	
Date of last occurrence	

b) Has there been any recurrence of attack in the past?
☐ Yes (please provide details below) ☐ No

Date or period	Details

c) Is there any investigation done?
☐ Yes (please provide details below) ☐ No

Date or period	Type of test done	Result

d) Please provide details of the diagnosis.

Exact diagnosis For example, depression, anxiety, schizophrenia, compulsive obsessive disorder, bipolar disorder.	
Contributory factors (if any) For example, work stress, marital conflicts, death of close relative, drugs or alcohol abuse.	
Date of diagnosis	

Questions for insured (continued)

Name (as shown in NRIC or FIN)	NRIC number or FIN	Proposal number(s)

e) Has your mobility, work, studies or daily activities ever been affected or restricted by this condition?
☐ Yes (please provide details below) ☐ No

Date or period	Details (including taking time off from work or studies, if any)

f) Have you ever had any suicidal thoughts or attempts?
☐ Yes (please provide details below) ☐ No

Date or period	Details

2 Treatment

a) Have you consulted or been referred to a doctor (including specialist) for this condition?
☐ Yes (please provide details below) ☐ No

Name and address of doctor	Date of first consultation	Date of last consultation	Result of last consultation

b) Have you been treated as an in-patient at any hospital or institution for this condition?
☐ Yes (please provide details below) ☐ No

Name of hospital or institution	Treatment or procedure	Admission date	Discharge date

c) Was there any medication, therapy or other treatment prescribed for this condition?
☐ Yes (please provide details below) ☐ No

Name or description	Dosage	Date or period

Questions for insured (continued)

Name (as shown in NRIC or FIN)	NRIC number or FIN	Proposal number(s)

3 Current Status

Tick the ones that are applicable and provide the required details.

☐ Have been fully discharged from medical follow up on _____ (dd/mm/yyyy)

☐ Still on regular treatment or medical follow up with doctor

Frequency	
Date of last consultation	
Date of next consultation	
Details of treatment	
Name and address of doctor	

☐ Waiting for further investigation or waiting for treatment

Planned date	
Description	
Name and address of doctor	

☐ Others (please provide details below)

Details

4 Medical Report

Please submit a copy of inpatient discharge summary or investigation or medical report(s).

☐ Attached ☐ Not available

Declaration by the proposer and insured

I declare that the answers in this form are true, correct and complete, and I have not withheld any relevant information. I accept full responsibility for them, whether written by me or by anyone else on my behalf.

I acknowledge and agree that this form will constitute part of my application for life or health insurance, and will form the basis of the contract of insurance. If anything is untrue, incorrect or incomplete, the insurance policy will not be valid.

I confirm that there has been no change in the insured's health since the completion of the application and all additional declarations made in connection with the application.

Signature of proposer	Signature of insured (for age 16 and above)
Date (dd/mm/yyyy):	Date (dd/mm/yyyy):