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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

Gynaecological disorder 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 Please provide details on the diagnosis.

Exact diagnosis	Underlying cause	Date of diagnosis
For example, endometriosis, dysmenorrhoea, ovarian cyst, abnormal pap smear.		

2 What were the signs and symptoms experienced?

Description of signs and symptoms	Date of first occurrence	Date of last occurrence
For example, abnormal uterine or vaginal bleeding, irregular menses, painful menses, absent of menses, abnormal enlargement of abdomen.		

3 What was the frequency of recurrence in the past?

Note: Please provide frequency of attack and dates of each attack.

4 Have any tests been done for this condition (for example, ultrasound, biopsy, pap smear test)? ☐ Yes (please provide details) ☐ No

Type of tests	Result	Date of tests

5 Please provide the nature of this condition: ☐ Cancerous (please provide details) ☐ Non-cancerous

Note: Please indicate the stage of cancer upon diagnosis.

6 Did the cancer spread to any lymph nodes and/or other parts of the body? ☐ Yes (please provide details) ☐ No ☐ Not applicable

Note: Please indicate which site/part of the body/organ affected.

Questions for insured (continued)

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

7 Have you been prescribed with any medications, therapy or treatment for this condition (for example, surgery, medication, radiotherapy, chemotherapy)?
☐ Yes (please provide details) ☐ No

Type of medication, therapy or treatment	Dosage	Start date	End date

8 Have you been hospitalised or have you undergone any surgery or procedure for this condition? ☐ Yes (please provide details) ☐ No

Treatment/Procedure	Name of clinic/hospital	Admission date	Discharge date

9 Please provide details on follow-up.

Date of last follow-up	Date of next follow-up	Type of tests or investigations done and results (if any)	Doctor's advice

Frequency of review with doctor: ☐ monthly ☐ quarterly ☐ half yearly ☐ yearly ☐ others _____

10 Has any further treatment, surgery, investigation or repeat tests been discussed/recommended/planned to be done in the future?
☐ Yes (please provide details) ☐ No

Note: Please include the details of discussion, recommendation and planned date(s).

11 Is there any complication or related medical condition? ☐ Yes (please provide details) ☐ No

Date of onset	Diagnosis/Conditions	Treatment

Questions for insured (continued)

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

12 Have you ever taken time off from work/studies due to this condition? ☐ Yes (please provide details) ☐ No

Dates	Number of days off from work/studies

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

Note: Please include the details of the movement and activities that have been affected.

14 Please provide details regarding the doctors (including specialists) whom you have consulted or been treated for this condition.

Date/Period of visit	Name of doctor	Name & address of clinic/hospital

Note: Please submit copy of medical/inpatient discharge summary/investigation/histology report(s) if 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):