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

Autism 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 type(s) of autism are you suffering from (for example, Autistic disorder or Asperger's syndrome)?

Exact diagnosis	
Underlying cause	
Date of diagnosis	

b) What symptoms did you experience?

Description of symptoms	
Date of first occurrence	
Date of last occurrence	
Number of episodes in the last 12 months	

c) Are there any complications (for example, mental retardation, fits or seizures)?
☐ Yes (please provide details below) ☐ No

Details

d) Are there any investigations done (for example, IQ test, psychological test, audiologic assessment or lead screening)?
☐ Yes (please provide details below) ☐ No

Date	Type of test done	Result

2 Treatment

a) Have you seen a doctor?
☐ Yes (please provide details below) ☐ No

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

b) Have you ever been hospitalised for this condition?
☐ Yes (please provide details below) ☐ No

Date	Duration of stay	Reason for hospitalisation	Treatment	Name of hospital

Questions for insured (continued)

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

c) Have you ever had surgery done or is there any intention to do so in the future?

☐ Yes (please provide details below) ☐ No

Date	Nature of procedure	Name of hospital

d) Was there any medication, therapy or other treatment prescribed?

☐ Yes (please provide details below) ☐ No

Name or description	Dosage	Date or period

3 Current Status

Please tick the ones that are applicable and provide the required details.

☐ Have fully recovered on _____ (dd/mm/yyyy)
(i.e. no recurrence, no symptom, no complication, no resulting disability or restriction in activities and fully discharged from medical follow up)

☐ Still on regular treatment or medical follow-up with doctor

Frequency	
Date of last consultation	
Name and address of doctor	

☐ Waiting for further investigation or waiting for treatment or surgery

Planned date	
Description	
Name and address of doctor	

☐ Others (please provide details below)

Details

Please submit a copy of medical report or school assessment report or psychological 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):