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NTUC Income Insurance Co-operative Limited
Income Centre 75 Bras Basah Road Singapore 189557
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an NTUC Social Enterprise

Product Type

- ☐ Affinity
- ☐ DPS
- ☐ Employee Benefit
- ☐ ElderShield
- ☐ IncomeShield
- ☐ Life Insurance

Chest pain 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

2 Please provide the details of occurrences.

Date of first occurrence	
Date of last occurrence	
Number of episodes in last 12 months	

3 Please provide details of chest pain below:

Mode of onset	Location and radiation of the pain	Nature of the pain
For example, at rest, only on exertion ceasing with rest, only with certain postures, sudden, gradual.	For example, central, in the left or right side of the chest, across the front of the chest.	For example, vague discomfort, tightness, sharp, crushing, stabbing, dull pain.

Did the pain radiate outside the chest to the shoulders, arms, jaw and abdomen? ☐ Yes (please provide details) ☐ No

How long did the chest pain usually last?	

4 Have any tests been done for this condition (for example, resting ECG, treadmill ECG, thallium scan, angiogram, CT scan, echocardiogram, endoscopy, blood test.)? ☐ Yes (please provide details) ☐ No

Type of tests	Result	Date of tests

Questions for insured (continued)

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

5 Have you been prescribed with any medications, therapy or treatment for this condition? ☐ Yes (please provide details) ☐ No

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

6 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

7 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 ____________

8 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).

9 Have you ever suffered from any of the following medical conditions? ☐ Yes (please tick the ones which you have) ☐ No

Medical conditions
☐ High blood pressure ☐ Raised cholesterol ☐ Stroke ☐ Diabetes ☐ Valvular heart disease

10 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

Questions for insured (continued)

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

11 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.

12 Do you smoke cigarettes/cigars?

☐ Yes, (number of sticks per day: ____________, number of years: ____________. ☐ No

13 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):