

Product Type									
Affinity	ElderShield								
DPS	IncomeShield								
Employee Benefit	Life Insurance								

821/033

## **Diabetes mellitus 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 fo	or insi	ured				
1	Please provide details	of the diagnosis	i.							
	Type of diabetes (for example, Type 1, Type 2 or gestational)									
	Date of diagnosis									
2										
2	<ul> <li>2 Did you ever experience symptoms like blurred vision, diabetic or insulin coma, dizziness, chest pain and reduced physical ability?</li> <li>         Yes (please provide details below)         No     </li> </ul>									
	Details to include symptoms experienced, date experienced at onset and last experienced, investigations done and results.									
3	Have you ever been h		re?							
	Yes (please provide Please enclose a copy		harge or clinical	summaries	∐ No	o closed	Not availab	ام		
	Date	Duration of s		Reason or diag		ciosed		Name of hospital		
4	Are you on regular fol		octor?		No					
Yes (please provide details below)     No										
	Date of last consultation									
Name and address of doctor										
5	Are you on insulin?									
	Yes (please provide Type of in		D	Dosage		No Date or period		Frequency		
				00050	Dute of p			Пециенсу		
6 What treatment has been prescribed by your doctor?  Diet only Diet and medications (please provide details below)										
	Name of medication					Dosage		Date or period		

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Questions for insured (continued)								
Na	ame (as shown in NRIC	or FIN)		NRIG	C number or FIN	Proposal number(s)		
7	Please provide your H	IbA1c (glycosylated haemoglobin) readin	ngs below.					
			HbA1c readings					
	Latest							
	3 months ago							
	1 year ago							
8       Has any investigation (for example, ECG or blood test) or health screening been done?            Yes (please provide details below)           No								
	Please enclose a copy	of the medical reports.	Enclosed	Enclosed Not available				
	Type of inv	estigation or health screening	Date pe	erformed		Result		
9		d from any of the following medical cont e ones which you have)	ditions?					
	Medical conditions							
	Heart problem	Raised blood pressu		holesterol		problem or urine abnormalities		
	Stroke Circulatory problem of the legs Others							
	Details to include name of medical conditions, date of diagnosis, investigations done and results.							
		Declaration	n by the pr	oposer an	d insured			
		s in this form are true, correct and compl r by anyone else on my behalf.	lete, and I hav	ve not withhe	ld any relevant information. I	accept full responsibility for them,		
lf a	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.							
Sig	gnature of proposer			Signature of	insured (for age 16 and above	2)		
Da	ate (dd/mm/yyyy):			Date (dd/mm	ה/עעע):			