OPTIMUM GLOBAL
INTERNATIONAL INSURANCE SOLUTIONS

SUPPLEMENTARY QUESTIONNAIRE FOR MEDICAL CONDITION

(ALL questions to be duly completed by the proposer)

APPLICANTS NAME: _____

1. Please state the final diagnosis or exact nature of the condition made by your doctor?

   _____

2. (a) When was this condition first diagnosed? _____

   (b) How was this condition discovered? (eg. health screening, family history) _____

3. (a) Have you ever been hospitalized? If so, please give details _____

   (b) What were the presenting symptoms? _____

   (c) How frequently do you experience the symptoms/attacks? _____

   (d) Do you still have the symptoms? Yes ☐ No ☐

   If YES, are they constant, variable, improving or progressively worsening? _____

   (e) When was your last symptoms/attack? _____

   (f) Are you aware of any specific factors that trigger your symptoms? (eg. exercise, allergy) Yes ☐ No ☐

   If YES, please provide details: _____

4. (a) Name and address of your attending doctor/specialist? _____

   (b) When was your last consultation? _____

   (c) Are you still attending any regular out-patient or specialist follow-up? Yes ☐ No ☐

   If YES, please provide details (eg. how often?): _____

   If NO, have you been discharged? _____

   (d) Have you fully recovered from the condition? Yes ☐ No ☐

   If NO, please provide details: _____

5. Have you done or pending to do any type of investigations (eg. ultrasound, scan, blood tests?) Yes ☐ No ☐

   If YES, please provide full details, dates, type of investigations, findings and attach copy of the results.

   _____

6. Have you had an operation for this condition or is an operation being considered? Yes ☐ No ☐

   If YES, please provide full details including date(s) and type of operation:

   _____

7. Please provide details of all treatment taken – including names of medication, dosage, how often and any other form of treatment/therapy received:

   (a) Currently: _____

   (b) In the past: _____

   (c) If not on medication/treatment now, please state why & date of cessation: _____

8. Do you still have any recurrence of symptoms or complications arising from this condition since the last consultation or operation?

   _____

9. (a) Dates and duration of any time lost from work/school due to the condition? _____

   (b) Has the condition caused you to change or reduce your non-occupational activities (eg. sports, hobbies, mode of transport etc)? Yes ☐ No ☐

   If YES, please provide details: _____

*Please attach copies of all reports, if available.

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Important Note:

I agree to inform Optimum Global Ltd if there is any change in the state of my health or my activities between the date of this Health Declaration and the date full insurance coverage is provided by Optimum Global Ltd to me. I understand that the terms of accepting me as a risk for insurance coverage may vary according to such information received. I declare that the information given is true and complete and that I have not withheld any material information that may influence the assessment of my application.

Main Applicant's Name: _____ NRIC No.: _____

Main Applicant's Signature: _____ Date: _____

IF DETAILS ARE REQUESTED ON THE DEPENDANT'S LIFE, PLEASE ALSO COMPLETE THE FOLLOWING:

Dependant's Name: _____ NRIC No.: _____

Dependant's Signature: _____ Date: _____