



SUPPLEMENTARY QUESTIONNAIRE FOR MEDICAL CONDITION - CHILD ALONE

(ALL questions to be duly completed by the Parent/Guardian)

CHILDS NAME: _____

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

2. (a) When was this condition first diagnosed? _____
(b) How was this condition discovered? (eg. health screening, family history) _____
3. (a) Has your child ever been hospitalized? If so, please give details _____
(b) What were the presenting symptoms? _____
(c) How frequently does your child experience the symptoms/attacks? _____
(d) Does your child still have the symptoms? Yes No
If YES, are they constant, variable, improving or progressively worsening? _____
(e) When was the last symptoms/attack? _____
(f) Are you aware of any specific factors that trigger the symptoms? (eg. exercise, allergy) Yes No
If YES, please provide details: _____
4. (a) Name and address of your child's attending doctor/specialist? _____
(b) When was your child's last consultation? _____
(c) Is your child still attending any regular out-patient or specialist follow-up? Yes No
If YES, please provide details (eg. how often?): _____
If NO, have they been discharged? _____
(d) Has your child fully recovered from the condition? Yes No
If NO, please provide details: _____
5. Has your child 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. Has your child 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. Does your child 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 your child to change or reduce their 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.



Important Note:

I agree to inform Optimum Global Ltd if there is any change in the state of my child's health or activities between the date of this Health Declaration and the date full insurance coverage is provided by Optimum Global Ltd. I understand that the terms of accepting my child 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 child's application.

Parent/Guardian Name:

Parent/Guardian Signature:

Date:
