

Product Type

- | | |
|---|---|
| <input type="checkbox"/> Affinity | <input type="checkbox"/> ElderShield |
| <input type="checkbox"/> DPS | <input type="checkbox"/> IncomeShield |
| <input type="checkbox"/> Employee Benefit | <input type="checkbox"/> Life Insurance |

Mountaineering and rock climbing questionnaire

Details of insured

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

1	Type of activity: <input type="checkbox"/> Mountaineering <input type="checkbox"/> Rock climbing	
2	How long have you been climbing? (Years/Months)	
3	How often do you climb and where do you usually climb? <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">Please provide details of the location(s), length of expedition and frequency of trips per annum.</div>	
4	Please provide the following information: (a) Type of terrain (e.g. rocks, ice, snow, artificial climbing walls etc.) _____ (b) Degree of difficulty (easy, moderate, difficult, severe) _____ (c) Average height climbed to (in metres) _____ (d) Maximum height climbed to (in metres) _____	
5	You usually climb: <input type="checkbox"/> Alone <input type="checkbox"/> Accompanied	
6	Do you intend to climb in the future? <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">If yes, please advise the intended location(s) and length of expedition.</div>	<input type="checkbox"/> Yes <input type="checkbox"/> No
7	Are you a member of any climbers related club or association? <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">If yes, please provide details.</div>	<input type="checkbox"/> Yes <input type="checkbox"/> No
8	Have you ever suffered from any illness or injury as a result of mountaineering / rock climbing, or have you had an accident while climbing? <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">If yes, please provide details.</div>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Details of insured

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