

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 |

Drug 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

<p>1 Are you currently using or have you used any of the following, other than for treatment of a medical condition under proper medical supervision?</p> <p>(a) Amphetamines e.g. 'Ecstasy', 'Ice', MDMA, 'Speed', 'Uppers', etc</p> <p>(b) Barbiturates e.g. 'Downers', etc</p> <p>(c) Cannabis e.g. 'Hashish', Marijuana, 'Pot', 'Weed', etc</p> <p>(d) Cocaine e.g. 'Coke', 'Crack', 'Snow', etc</p> <p>(e) Hallucinogens e.g. 'Acid', 'Angel dust', 'Haze', LSD, 'Microdots' etc</p> <p>(f) Herbs e.g. catnip, poppy, kavakava, lobelia, etc</p> <p>(g) Opiate e.g. Codeine, Heroin, Methadone, Morphine, Opium, 'Smack', etc</p> <p>(h) Sedatives e.g. Diazepam, 'Downers', Nitrazepam, 'Tranks', etc</p> <p>(i) Solents e.g. Aerosols, glue, etc</p> <p>(j) Others</p> <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> <p>If yes, please provide full details including the date(s), name of drug(s), usual quantity used, frequency of use, method use and duration of usage.</p> </div>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>2 Have you sought medical treatment due to drug usage or detoxification?</p> <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> <p>If yes, please provide name(s) of doctors attended for supervision/detoxification.</p> </div>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>3 Have you suffered from any conditions or impairments associated with drugs, e.g. hepatitis B, HIV infection, mental illness, etc?</p> <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> <p>If yes, please specify the condition, date and treatment.</p> </div>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>4 Are you now drug free?</p> <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> <p>If yes, please state date of last usage.</p> </div>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

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):