Etiqa Insurance Pte Ltd (Company Reg. No. 201331905K)
One Raffles Quay #22-01 North Tower Singapore 048583 | T +65 6336 0477 | F +65 6339 2109 | www.etiqa.com.sg

Medical Examination Form (Juvenile)

For children aged 16 and below

WARNING: PURSUANT TO SECTION 23(5) OF THE INSURANCE ACT 1966, YOU ARE TO DISCLOSE IN THIS PROPOSAL FORM FULLY AND FAITHFULLY, ALL THE FACTS WHICH YOU KNOW OR OUGHT TO KNOW, OTHERWISE THE POLICY MAY BE VOID.

Full name of Life to be Insured (as shown in NRIC/Passport)		
NRIC / Passport Number / FIN	Date of Birth (dd/mm/yyyy)	Gender ☐ Male ☐ Female
Full name of Proposer		NRIC / Passport Number / FIN

Statement to the Medical Examiner

What is the name and address of the child's regular doctor or any doctor that the child has visited in the last 3 years?

Name of Doctor	Address of Doctor/Clinic

Date and reason of the child's last visit to the doctor

Is the child currently taking any medication? ☐ Yes ☐ No

If yes, please state reason and type of medication:

A. Lifestyle Details *(to be completed for children aged 10 and above)*

Please tick (✓) the relevant boxes.		If yes, please provide details
1 (a) Has the child used any tobacco products in the last 24 months? If yes, please indicate the date the child last smoked.	☐ Yes ☐ No	
(b) Does the child smoke currently?	☐ Yes ☐ No	_____ sticks per day for _____ years
(c) Does the child consume beer, wine or other alcoholic beverage?	☐ Yes ☐ No	____ can of beer (330ml) _____ glass of wine (per 125ml) _____ glass of spirit (per 30ml)
(d) Has the child ever taken addictive drugs / narcotics or been treated for alcoholism or drug addiction?	☐ Yes ☐ No	

B. Health Details

Please tick (✓) the relevant boxes.		If yes, please provide **FULL** details,
2 Has the child ever been told or treated for: (a) Premature birth or abnormal birth weight or delivery complications?	☐ Yes ☐ No	
(b) Congenital disorder/birth defect, any growth or developmental delay?	☐ Yes ☐ No	
(c) Diabetes, thyroid disorders or any other endocrine disorders, jaundice, hepatitis B carrier or any form of hepatitis, liver disorder or gall bladder disorder?	☐ Yes ☐ No	
(d) Ear discharge, nose bleeds, double vision, impaired sight, hearing or speech or any other disorders of ear, eye, nose or throat?	☐ Yes ☐ No	
(e) Asthma, bronchitis, persistent cough, pneumonia, respiratory distress syndrome, chest or breathing complaints/discomfort or any other lung disorders?	☐ Yes ☐ No	
(f) Coeliac disease, prolonged jaundice, hepatitis, recurrent indigestion, gastritis, passage of blood or mucous from the bowel or any other disease or disorder or the liver, stomach, gallbladder, pancreas, bowel or intestines?	☐ Yes ☐ No	
(g) Systemic Lupus Erythematosus, rheumatic fever, rheumatoid arthritis, Kawasaki disease or any other disorders of the immune system?	☐ Yes ☐ No	
(h) Blood, protein or sugar in urine, kidney stones, infection, or any other disorders of the kidney, bladder, or genital organs?	☐ Yes ☐ No	
(i) Congenital deformity, mental retardation, muscular weakness, fracture or amputation or any other injury to or disease or disorder of the spine, bones, muscles or joints?	☐ Yes ☐ No	

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B. Health Details (cont'd)

(j) Cancer, tumours, cyst or growths of any kind?	☐ Yes ☐ No	
(k) Anaemia, thalassaemia, haemophilia, recurrent infection, or any other problem of disease or disorder of the immune system, blood, blood cells or bone marrow or any enlarged lymph node or other lymph node disorder?	☐ Yes ☐ No	
(l) Any other illness, disorder, operation, physical disability or accident not mentioned above?	☐ Yes ☐ No	
3 In the past 5 years, has the child had any: (a) Tests done or been told to undergo tests such as X-ray, ultrasound, CT scan, biopsy, electrocardiogram (ECG), blood or urine test?	☐ Yes ☐ No	
(b) Illness, operation, medical advice, hospital treatment not mentioned above?	☐ Yes ☐ No	
4 Does the child have any other physical defects or health impairments?	☐ Yes ☐ No	
5 Does the child have any symptom or medical concern for which has not consulted a doctor or had any consultation, testing or investigation recommended by a doctor which has not yet be completed?	☐ Yes ☐ No	
6 Has the child's weight changed more than 5kg in the past year? If so, what is/are the reasons?	☐ Yes ☐ No	
7 Within the past 14 days, has the child had any contact with someone confirmed as infected with COVID-19?	☐ Yes ☐ No	
8 Has the child been issued any notice or directive to self-quarantine or stay home?	☐ Yes ☐ No	
9 Has the child been tested positive for COVID-19? If Yes, proceed to 9 (a) and (b)	☐ Yes ☐ No	
(a) Has the child been hospitalised for COVID-19? If yes, to state date of period admission and date of discharged	☐ Yes ☐ No	
(b) Has the child recovered fully with no complications or sequelaes?	☐ Yes ☐ No	
10 Has any proposal for coverage on the child's life ever been declined, withdrawn, postponed, rated, reinstated or modified in any way? If yes, please state name of insurer, reasons for substandard term or decline, acceptance term	☐ Yes ☐ No	
11 Are you making or have you made any claims on the child, including hospitalisation claims on any policy with Etiqa or any other insurer? If yes, please state name of insurer, type of claims	☐ Yes ☐ No	

C. Family History

12 Has the child's biological parents or siblings been diagnosed with or passed away as a result of: Alzheimer's disease, cancer, carcinoma-in-situ, mental disorder, diabetes, polycystic kidney disease, stroke, high blood pressure, heart disease, or any other hereditary disease or disorder? If yes, please provide details below.

Relationship	Type of Illness	Age / Year of Onset	Cause of Death (if deceased)	Age of Death (if deceased)

Declaration

1. I declare I am the parent / legal guardian of the child to be insured and that all the information given above are, to the best of my/our knowledge, true and complete and I have not withheld any material information that may influence the assessment of our application. I further agree that the information given above shall form the basis of our application for insurance and any material fact known to me may invalidate the contract of insurance
2. I authorise Etiqa Insurance Private Limited ("the Company") to obtain, if necessary confidential reports from any doctor/clinic/hospital that I have referred above.
3. I agree to inform Etiqa Insurance Private Limited ("the Company") if there is any change in my state of health or any information provided in this form from the date I signed to the issued date of my policy. I understand that the Company may vary the acceptance term or void the contract according to such information received.

I further agree and consent that Etiqa Insurance Private Limited may collect, use, process and disclose the personal data in accordance with the terms and condition as stated in the insurance application form and/or the Etiqa Insurance, Singapore's Data Protection Policy available at www.etiqa.com.sg which I have read, understood and agreed to the same.

Signature of Parent / Legal Guardian	Signature of Medical Examiner
Name:	Name:
NRIC:	NRIC:
Date:	Date:

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Medical Examiner's Confidential Report

A. Physical Examination

Height _____ cm	Weight _____ kg

Is there any recent significant weight change? ☐ Yes ☐ No
If yes, please specify.

Is the above height and weight within the normal range? ☐ Yes ☐ No

If no, please provide reason(s) for the abnormal range.

Head Circumference for children up to 12 months: _____ (cm) Percentile of Head Circumference: _____ %

Visual Acuity	Left Eye	Right Eye
Uncorrected		
Corrected		

Please tick (✓) the relevant boxes.		If yes, please provide **FULL** details of findings.
1 (a) Is there any evidence of visual, hearing or speech impairment or eye, ear, nose or throat abnormalities?	☐ Yes ☐ No	
(b) Hearing acuity: Are there any difficulties in hearing normal conversation?	☐ Yes ☐ No	
2 (a) Is there any evidence of abnormality in the Central Nervous System and Musculo-skeletal System?	☐ Yes ☐ No	
(b) Is there any abnormalities in gait, joint mobility, power, tone or reflexes?	☐ Yes ☐ No	
(a) Are there any paralysis, tremors, or evidence of neurological abnormalities?	☐ Yes ☐ No	
(b) Is there any evidence of diseases of the spine or joints?	☐ Yes ☐ No	
(c) Is there any abnormality in the chest symmetry and movements?	☐ Yes ☐ No	
(d) Percussion: Are there any areas of pathological dullness?	☐ Yes ☐ No	
(e) Auscultation: Are there any abnormal breath sounds?	☐ Yes ☐ No	
3 (a) Pulse Rate and Rhythm: If pulse is irregular or pulse >90 or <50/min, please repeat twice at intervals of 10 minutes each.	Pulse / 1 / 2 / 3 Rate (per min) Rhythm: ☐ Regular ☐ Not Regular	
(b) Is there any abnormality in the apex beat? State where the apex beat is felt.	☐ Yes ☐ No	
(c) Are there any murmurs? If yes, please state type, site and grade.	☐ Yes ☐ No	
(d) Is there any cyanosis or undue breathlessness on exertion?	☐ Yes ☐ No	
(e) Is there any sign of hypertrophy or dilation?	☐ Yes ☐ No	
4 (a) Are the liver, spleen and kidneys palpable?	☐ Yes ☐ No	
(b) Is there any evidence of hernia, liver, spleen, or other abdominal abnormalities?	☐ Yes ☐ No	
(c) Is there any evidence of diabetes, or disease of thyroid or endocrine glands?	☐ Yes ☐ No	
(d) Is there any evidence of diseases of the urinary and genital organs?	☐ Yes ☐ No	

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A. Physical Examination (cont'd)

5 (a) Please test urine with a dipstick and indicate results. If any protein or blood results are "1+" or higher, please proceed with UFEME.
For female, if blood is present, please state LMP.

Blood	Sugar	Albumin	Specific Gravity

(b) Is there any evidence of blood, protein or sugar in urine, kidney stones, infection or any other disorders of the kidney, bladder or genital organs?	☐ Yes ☐ No	
6 (a) Are there any scars or other signs of disease past or present?	☐ Yes ☐ No	
(b) Is there any visible growth, tumour or enlargement? If yes, please state its location and nature.	☐ Yes ☐ No	
7 (a) Is there any other evidence of illness, disorder, injury or disability?	☐ Yes ☐ No	
(b) Is there any significant change in the Examinee's appetite, weight and bowel habits recently?	☐ Yes ☐ No	
(c) Is there any further evidence of medical in the family history which you think are significant?	☐ Yes ☐ No	

B. Doctor's Declaration

Please tick (✓) the relevant boxes.		If yes, please provide details
1. Have you seen the Examinee professionally before? If yes, we would appreciate it if you could review your records to confirm that all items of the Examinee's physical history has been declared.	☐ Yes ☐ No	
2. Do you recommend any additional tests or reports?	☐ Yes ☐ No	
3. Do you consider that there are any circumstances that may adversely affect the Examinee's life expectancy and risk of disability and dread diseases?	☐ Yes ☐ No	

I certify that I have this day examined and identified the Examinee who is the Life to be Insured named on this form.

The examination has been conducted in private on _____ (dd/mm/yyyy) at:

Clinic Name & Address: _____

Signature of Medical Examiner: _____

Name & Qualification: _____

Clinic Stamp