income made different

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Product Type
☐ Affinity ☐ ElderShield
☐ DPS ☐ IncomeShield
☐ Employee Benefit ☐ Life Insurance

Drug questionnaire

Details of insured

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

Questions for insured

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?

(a)	Amphetamines e.g. 'Ecstasy', 'Ice', MDMA, 'Speed', 'Uppers', etc	☐ Yes ☐ No
(b)	Barbiturates e.g. 'Downers', etc	☐ Yes ☐ No
(c)	Cannabis e.g. 'Hashish', Marijuana, 'Pot', 'Weed', etc	☐ Yes ☐ No
(d)	Cocaine e.g. 'Coke', 'Crack', 'Snow', etc	☐ Yes ☐ No
(e)	Hallucinogens e.g. 'Acid', 'Angel dust', 'Haze', LSD, 'Microdots' etc	☐ Yes ☐ No
(f)	Herbs e.g. catnip, poppy, kavakava, lobelia, etc	☐ Yes ☐ No
(g)	Opiate e.g. Codeine, Heroin, Methadone, Morphine, Opium, 'Smack', etc	☐ Yes ☐ No
(h)	Sedatives e.g. Diazepam, 'Downers', Nitrazepam, 'Tranks', etc	☐ Yes ☐ No
(i)	Solents e.g. Aerosols, glue, etc	☐ Yes ☐ No
(j)	Others	☐ Yes ☐ No

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.

2 Have you sought medical treatment due to drug usage or detoxification? ☐ Yes ☐ No

If yes, please provide name(s) of doctors attended for supervision/detoxification.

3 Have you suffered from any conditions or impairments associated with drugs, e.g. hepatitis B, HIV infection, mental illness, etc? ☐ Yes ☐ No

If yes, please specify the condition, date and treatment.

4 Are you now drug free? ☐ Yes ☐ No

If yes, please state date of last usage.

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):