

CONFIDENTIAL MEDICAL QUESTIONNAIRE

INSTRUCTIONS TO EXAMINER

- If any party to this examination has a personal or professional relationship with the Proposed Insured, please do not proceed
- Please answer every question and complete this questionnaire in English
- Please obtain and submit a certified true copy of the Proposed Insured's **identity document** presented during this examination. If you are not satisfied with the Proposed Insured's identity, or he or she is unable to provide satisfactory identification, please do not proceed with the examination
- A Physician (Cardiologist, Internist, Family Physician, or General Practitioner) or a Paramedical Examiner (Physician's Assistance, Nurse Practitioner, or Nurse) may complete this examination
- For a **Physician**, complete Section A, Section C and Section D with the Proposed Insured. Pay particular attention to any vital signs or other physical examination results/observations that relate back to the Proposed Insured's medical history
- For a **Paramedical Examiner**, complete Section A and Section C (Questions #1-4 only) with the Proposed Insured. A Paramedical Examiner will not complete section D
- The required laboratory tests are provided separately
- If the Proposed Insured requires assistance from an interpreter, please have the Interpreter Services Declaration completed by both the Proposed Insured and the Interpreter

PROPOSED INSURED INFORMATION (to be completed by Examining Physician, Physician's Assistant or Nurse)

Family Name/Last Name of Person Examined	Given Name/First Name of Person Examined	<input type="checkbox"/> Male	Date of Birth (dd/mm/yyyy)
		<input type="checkbox"/> Female	

Passport or government identity document of person examined:

Type of Identification	Passport Number or Government ID Number
Country of Issue	Date of Expiration (dd/mm/yyyy)

Please attach a legible certified copy of the identity document of person being examined.

Are you satisfied as to the identity of the person being examined?

 Yes No**IF YOU ARE NOT SATISFIED AS TO THE PERSON'S IDENTITY, OR HE OR SHE IS UNABLE TO PROVIDE SATISFACTORY IDENTIFICATION, PLEASE DO NOT PROCEED WITH EXAMINATION OR TESTING.**

Family Name/Last Name of Examiner	Given Name/First Name of Examiner
Examiner Address	
Examiner Signature	Date (dd/mm/yyyy)

PERSONAL HEALTH HISTORY (to be completed by Examining Physician, Physician's Assistant or Nurse)

Family Name/Last Name of Person Examined	Given Name/First Name of Person Examined	Date of Birth (dd/mm/yyyy)
--	--	----------------------------

SECTION A HEALTH DETAILS

1	Have you ever been treated for or had any symptoms or indication of the following	
a	High blood pressure, high cholesterol, angina, chest pain, heart attack, coronary artery disease, heart murmur, irregular heartbeat, transient ischemic attack (TIA), stroke or cerebrovascular accident (CVA), blood clot(s), peripheral vascular disease (poor circulation), aneurysm, or any other disease or disorder of the heart or blood vessels?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b	Anemia, hemophilia, or any other blood or bleeding disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c	Asthma, chronic obstructive pulmonary disease (COPD), emphysema, chronic or recurrent bronchitis, sleep apnea, sarcoidosis, cystic fibrosis, tuberculosis, persistent cough, hoarseness, shortness of breath or difficulty breathing, or any other respiratory disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d	Chronic anxiety, depression, burnout, chronic fatigue syndrome, attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD), eating disorder, schizophrenia, attempted suicide, any other psychological, emotional or nervous disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e	Hepatitis (including hepatitis carrier state), cirrhosis, jaundice, Crohn's disease, ulcerative colitis, irritable bowel syndrome, diverticulitis, persistent diarrhea, rectal or intestinal bleeding, ulcer (peptic or gastric), pancreatitis, or any other disease or disorder of the bowel, stomach, pancreas or liver?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION A HEALTH DETAILS (continued)

f	Diabetes, gestational diabetes, abnormal blood sugar, goiter, hyperthyroidism, hypothyroidism, lymph or gland disease or disorder, or any other thyroid, pituitary or endocrine disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g	Lupus, scleroderma, arthritis, fibromyalgia, muscular dystrophy, paralysis, or any other disease or disorder of the skin, connective tissue, muscles, joints, limbs, back or bones?	<input type="checkbox"/> Yes <input type="checkbox"/> No
h	Cancer, leukemia, lymphoma, melanoma, dysplastic nevus (atypical mole), basal cell carcinoma, tumor, cyst(s), polyp(s), any other growths or malignancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
i	Abnormal prostate specific antigen (PSA), prostatitis or any other prostate disease or disorder, breast lump(s) or cyst(s), abnormal mammogram or pap smear, hysterectomy, disease or disorder of the ovary or uterus, sexually transmitted disease, disease or disorder of the genital organs, kidney stone(s), nephritis, urinary tract infection, sugar, blood or protein in the urine, or any other kidney or bladder disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
j	Autism, cerebral palsy, Down syndrome, developmental delay, epilepsy or seizure(s), multiple sclerosis (MS), loss of balance, consciousness, sensation or speech, coma, concussion, severe headaches(s), dizziness, fainting, Parkinson's disease, tremor, Alzheimer's disease, dementia or cognitive impairment, amyotrophic lateral sclerosis (ALS), or any other disease or disorder of the brain or nervous system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
k	Any disorder of the eyes (excluding any vision impairment corrected with glasses or contact lenses), ears, nose, throat or mouth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	Have you ever been tested for or has anyone ever recommended that you be tested for exposure to the HIV (AIDS) virus?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3	Have you ever been treated for or had any indication of AIDS, HIV infection or any other disease or disorder of the immune system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4	Have you ever had a blood transfusion?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5	Other than for conditions already disclosed, in the past 5 years, have you had any medical or diagnostic tests, such as X-rays, ECG, scans, MRI, ultrasounds, biopsies or blood tests?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6	Have you been hospitalized or had any surgery in the past 10 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7	Do you have any symptoms for which you have not yet consulted a physician or received treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8	Other than for conditions already disclosed, has a doctor recommended any tests or referrals that have not yet been completed, or are you currently awaiting test results?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9	Do you have a deformity or an amputation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10	Are you taking any prescribed or non-prescribed medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11	For juveniles below 5 years old, please answer these questions	
a	Was the child born prematurely (less than 37 weeks of gestation) or with birth / congenital defects?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b	Has the child failed to meet any neurological or developmental milestones?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c	Has the child required any follow up or investigation for birth defects, congenital disorders or deformities, physical impairment, or delayed development?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d	In the past 5 years, has the child used any medication on a daily basis for over 21 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION A HEALTH DETAILS (continued)

12	If you answered "Yes" to any of the above questions #1 through #11, please provide details		
Question Number	Date of Occurrence (dd/mm/yyyy)	Details (diagnosis, tests, treatment, frequency/severity of symptoms, date of last symptoms)	Name and Address of Doctors, Medical Clinics or Hospitals

13	Have you ever used tobacco or nicotine products in any form (including but not limited to cigarettes, cigars, cigarillos, pipe, chewing tobacco, vaping, marijuana, nicotine patches, nicotine gum, hookah or shisha)? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide details		
	Product(s)	Amount(s)	Frequency of Use

14	In the past 10 years, have you used cocaine, LSD or other psychoactive drugs, heroin, or other narcotics? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide details		
	Product(s)	Amount(s)	Frequency of Use

15	Do you currently drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide details		
	Average Frequency of Consumption <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Less than once per month		
	On those days when you drink alcohol, how many drinks do you typically have?		

SECTION A HEALTH DETAILS (continued)

16 Have you ever received treatment or been advised to reduce use or frequency of use, seek treatment, counselling or medical advice or participated in any organizations / support groups due to your use of drugs or alcohol? Yes No
If "Yes," please provide details

Type of Counselling, Treatments, and/or Participation in Organizations / Support Groups	Start Date (mm/yyyy)	End Date (mm/yyyy)

17 Please complete the following table

Relationship to You	Current Age	Or Age at Death	Cause of Death
Father			
Mother			
Sibling(s)			
Sibling(s)			
Sibling(s)			

18 Have any of your biological parents, brothers or sisters ever been diagnosed with heart disease, stroke or transient ischemic attack (TIA), cancer, diabetes, Parkinson's disease, Huntington's disease, polycystic kidney disease (PKD), Alzheimer's disease, or any other hereditary disease or disorder not recorded in question #17? Yes No
If "Yes," please provide details

Relationship to You	Condition (if cancer include type)	Age at Onset	Age if Living	Age at Death

SECTION A HEALTH DETAILS (continued)

19	Do you have any regular doctor, attending physician and / or specialist doctor? If "Yes," please provide details below	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Doctor / Attending Physician		
Name of Medical Clinic or Hospital		
Full Address of Medical Clinic or Hospital		
Your Name on the Record (if different from name on ID / Passport)		Date of Last Consultation (dd/mm/yyyy)
Reason for Last Medical Consultation		
Treatment or Medication Prescribed		
Tests Performed and Results of All Tests		
If you do not have a regular doctor or any health care advisor, please provide the details regarding your last consultation with any doctor, health care provider at a medical clinic, or hospital		
Name of Doctor / Health Care Provider		
Name of Medical Clinic or Hospital		
Full Address of Medical Clinic or Hospital		
Your Name on the Record (if different from name on ID / Passport)		Date of Last Consultation (dd/mm/yyyy)
Reason for Last Medical Consultation		
Treatment or Medication Prescribed		
Tests Performed and Results of All Tests		

SECTION B CONSENT AND AUTHORISATION

The information obtained in this Confidential Medical Questionnaire is required in order for any life insurance company (the "Company") to consider your application for a life insurance policy (the "Policy"), insurability under the Policy and underwriting of the Policy. Submission of this Questionnaire to the Company does not oblige the Company to issue the Policy or enter into a Policy contract with, or involving, you. If you have any questions in relation to this Questionnaire, please refer to your Representative or seek independent advice, as you deem fit.

By signing below:

- I. I declare that the answers and statements to all of the questions are complete, correct, and true and shall form part of the application for insurance on my life. I have given full disclosure of information which could influence the Company's underwriting decision. I acknowledge that if I am unsure whether a particular fact is relevant, I should disclose it here in writing. I understand that if I do not completely, correctly, and truthfully answer all of the questions or I misrepresent my answers or statements the Company may void the policy. In addition to my answers to this form, information from other sources may be considered by the Company, as appropriate, and I agree to provide further information upon the Company's request.
- II. I acknowledge and agree that (i) to the extent required or permitted by laws or regulations applicable to the Company or its corporate parent(s), subsidiaries, or affiliates, the Policy and any person's interest therein may be reported to tax and regulatory authorities in Singapore or other applicable jurisdictions; and (ii) consent for the Company to collect, use, store, disclose and/or transfer my/our Personal Data (as defined in the Personal Data Protection Act 2012 ("PDPA")) to its corporate parent(s), subsidiaries or affiliates, agents, independent contractors or service providers, actual or potential assignees, novatees, transferees, successors, reinsurers, professional advisors, auditors, courts, tribunals, regulators, supervisory or governmental bodies or authorities, police, banks, financial institutions, credit reference agencies, nominees, stock exchanges, trade repositories, clearing houses, fund managers or administrators, issuers, underwriters, distributors or brokers, any person or entity who or which is entitled to demand or request for the Company to make a disclosure under laws and regulations or to whom it is in the Company's interests to make disclosure to perform its functions or meet its legal regulatory or other obligations, and/or any person or entity that the Company is required by a court or tribunal or regulator or governmental authority to make disclosure, for any of the following purposes (a) to process and evaluate an application, transaction, or request related to life insurance, annuity, investment account, or other product or service that the Company may offer; (b) to underwrite an application for any such product or service; (c) to administer and/or determine claims, coverage, benefits, and other features of such products or services; (d) to obtain reinsurance; (e) for any other purpose in connection with provision or enhancement of products or services which the Company may provide; (f) in connection with matching any Personal Data with other information in the Company's possession that relates to me/us; (g) to ensure compliance by the Company of its contractual, legal and regulatory obligations; (h) in connection with legitimate business interest of the Company, including but not limited to market analysis, management reporting, and risk management purposes. Where I provide the Company with Personal Data of any other individual, I consent that I have obtained the consent(s) from the individual(s) concerned to provide the same to the Company. I shall procure all relevant consents from the individual(s) concerned in respect of the persons to whom his/her Personal Data may be shared and the purposes for which his/her Personal Data may be collected, used, stored, transferred or disclosed, as stated above. I acknowledge and agree that the Company's rights in relation to my Personal Data as set out above shall continue notwithstanding any termination or cessation of any product or service by the Company. I recognise that Personal Data may be transferred out of the jurisdiction from where it was supplied, and that the standard of confidentiality and data protection in different jurisdictions may differ. I hereby waive any rights I may have that would prevent the Company from meeting any of the Company's legal or regulatory requirement.

Signature of Proposed Insured *	
Name of Proposed Insured	
ID / Passport Number of Proposed Insured	Date (dd/mm/yyyy)

***Where the Proposed Insured is below the age of 16 years, his/her parent/legal guardian should sign and provide identification and/or other documents as required by the Company.**

SECTION C HEALTH STATUS

1	Height centimetres	Weight kilograms	BMI
Did Proposed Insured's weight change over the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If "Yes," please provide details			
<input type="checkbox"/> Loss of <input type="checkbox"/> Gain of kilograms			
Reason			
2	Pulse per minute	Regular If "No," please provide details	<input type="checkbox"/> Yes <input type="checkbox"/> No
3	Blood pressure (seated) 1st Reading /	2nd Reading /	
4	Dipstick Urinalysis, please provide details		
	Protein	Sugar	Blood Date of last menses (dd/mm/yyyy)
5	Is there any abnormality of the following? If "Yes," please provide details in question #8 below		
a	Oral cavity, eyes, ears, nose, throat, skin (including xanthelasma, xanthomata, arcus senilis)?		<input type="checkbox"/> Yes <input type="checkbox"/> No
b	Lymph nodes or the thyroid gland?		<input type="checkbox"/> Yes <input type="checkbox"/> No
c	Chest, spine or extremities?		<input type="checkbox"/> Yes <input type="checkbox"/> No
d	Lungs on percussion and auscultation?		<input type="checkbox"/> Yes <input type="checkbox"/> No
6	Are any murmurs present? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes," please provide details for all murmurs below, and use question #8 for additional details			
	Location	Intensity	Timing
	<input type="checkbox"/> Apex	<input type="checkbox"/> Gr I <input type="checkbox"/> Gr II	Systolic
	<input type="checkbox"/> Base	<input type="checkbox"/> Gr III <input type="checkbox"/> Gr IV	
	<input type="checkbox"/> Intercostal space	<input type="checkbox"/> Gr V <input type="checkbox"/> Gr VI	Diastolic
	<input type="checkbox"/> Right of sternum		
	<input type="checkbox"/> Left of sternum		
	<input type="checkbox"/> Apex	<input type="checkbox"/> Gr I <input type="checkbox"/> Gr II	Systolic
	<input type="checkbox"/> Base	<input type="checkbox"/> Gr III <input type="checkbox"/> Gr IV	
	<input type="checkbox"/> Intercostal space	<input type="checkbox"/> Gr V <input type="checkbox"/> Gr VI	Diastolic
	<input type="checkbox"/> Right of sternum		
	<input type="checkbox"/> Left of sternum		
			Organic
			Physiologic
			Organic
			Physiologic

SECTION D MATURE AGE QUESTIONNAIRE
(Complete if the Proposed Insured is age 71 and over)

Please inform the Proposed Insured that this questionnaire is an assessment of their mobility, daily living activities and memory.

1	<p>Please tick all applicable boxes to indicate the Proposed Insured's physical activity level</p> <p><input type="checkbox"/> No mobility or gait limitations</p> <p><input type="checkbox"/> Uses Aids – please provide type (walking stick, cane, walker, wheelchair, other)</p> <p><input type="checkbox"/> Fall history in the past 5 years – please provide details (number of falls, dates, any injury)</p>
2	<p>Is there any evidence of cognitive disorder such as dementia, memory loss, confusion, behavioral change, lack of comprehension, etc.? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "Yes," please provide details</p>
3	<p>Does the Proposed Insured needs assistance with any activities of daily living including feeding, bathing, dressing, toileting, grooming and mouth care, transferring bed / chair, climbing stairs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "Yes," please provide details</p>
4	<p>Please record the time it takes for the Proposed Insured to get up from a seated position, walk 3 metres, return and sit again</p> <p style="text-align: center;">seconds</p> <p>Please provide comments</p>
5	<p>In the space below, please ask the Proposed Insured to:</p> <ul style="list-style-type: none"> ▪ Draw a circle ▪ Mark in all the numbers to indicate the hours of a clock ▪ Mark hands on the clock to show 10 minutes past 9 o'clock (9:10)

SECTION E EXAMINER INFORMATION AND SIGNATURE

By signing below:

I. I hereby confirm that

I completed Section A, OR

I did not complete Section A. The person who completed Section A with the Proposed Insured is

Surname / Family Name / Last Name
Given Name / First Name
Job Title

II. I, as the Physician, completed Section C and Section D (if the Client is age 70 years or over) OR

I, as the Paramedical Examiner, completed Section A and Section C (Questions #1-4)

III. I confirm that the information provided in this Questionnaire is complete, true and correct, AND I am satisfied with the identity of the person being examined

IV. I consent to the collection, use, storage, transfer and disclosure by the Company of my Personal Data (as defined in the Personal Data Protection Act 2012) contained in (or included with) this Questionnaire for the purpose of Proposed Insured's application for life insurance with the Company

Physician's / Examiner's Signature	Date (dd/mm/yyyy)
Surname / Family Name / Last Name of Physician	
Given Name / First Name of Physician	
Current Specialty	Medical License Number
Practice Address	
<p>Did you complete the medical examination at your normal place of practice and in a medical examination room? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "No," where was the medical examination completed?</p>	
<p>Did you or the person completing Section A with the Proposed Insured, or a third party act as an interpreter for the Proposed Insured? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "Yes," please provide an Interpreter Services Declaration form.</p>	

Sun Life Assurance Company of Canada Singapore Branch
50 Raffles Place, #26-04, Singapore Land Tower
Singapore 048623

Tel: +65 6223 1102 | Website: www.sunlife.com.sg

Sun Life Assurance Company of Canada is an insurance company federally incorporated in Canada, with OSFI Institution Code F380 and its registered office at 1 York Street, Toronto, Ontario, Canada M5J 0B6. It is regulated by Office of the Superintendent of Financial Institutions, Canada. Sun Life Assurance Company of Canada Singapore Branch (UEN T19FC0132B) is registered with the Accounting and Corporate Regulatory Authority of Singapore as a foreign company, with its registered office at 50 Raffles Place, #26-04, Singapore Land Tower, Singapore 048623. It is licensed and regulated by the Monetary Authority of Singapore. Where Sun Life Assurance Company of Canada Singapore Branch is referred to as "Sun Life Singapore," this is strictly for marketing and branding purposes only, and no legal significance is expressed or implied. Sun Life Assurance Company of Canada is a member of the Sun Life group of companies. The Sun Life group of companies operates under the "Sun Life" name. Sun Life Financial Inc., the publicly traded holding company for the Sun Life group of companies, is not a product offering company and is not the guarantor of the obligations of its subsidiaries.

©2025 Sun Life Assurance Company of Canada. All rights reserved.

The name Sun Life and the globe symbol are registered trademarks of Sun Life Assurance Company of Canada.