NAVIGATOR
Insurance Brokers Ltd.
Unit 8E, Golden Sun Centre, 223 Wing Lok St, Sheung Wan, Hong Kong
Tel : +852 2530 2530 | Fax : +852 2530 2535
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# CARE & HEALTH

# YOUR HEALTH DECLARATION FORM

Henner

*Please complete this health declaration for yourself and any dependent (spouse or child) that you have named in your Application Form*

## KINDLY COMPLETE YOUR HEALTH DECLARATION

| | | Main Insured | Spouse | Child 1 | Child 2 | Child 3 |
|---|---|---|---|---|---|---|
| 1 | Last name | | | | | |
| 2 | First name | | | | | |
| 3 | Date of birth (DD/MM/YYYY) | | | | | |
| 4 | Height ☐ Cm ☐ Inches | | | | | |
| 5 | Weight ☐ Kg ☐ lbs | | | | | |
| 6 | Gender | ☐ M ☐ F | ☐ M ☐ F | ☐ M ☐ F | ☐ M ☐ F | ☐ M ☐ F |
| 7 | Have you smoked over the past seven years?<br>*If yes, kindly indicate the average number of cigarettes smoked per day and when you ceased smoking if relevant* | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 8 | Over the past 10 years, have you undergone: | | | | | |
| a. | A surgery? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| b. | A laser treatment, chemotherapy, radiation therapy? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 9 | Over the past 5 years, have you been afflicted by an illness or involved in an accident that resulted in: | | | | | |
| a. | Sick leave for over 3 consecutive weeks? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| b. | Having to undergo medical treatment for over a month? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 10 | Have you suffered from or ever been diagnosed for: | | | | | |
| a. | Nervous disorders (chronic fatigue, anxiety, depression, migraine, epilepsy) | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| b. | Spinal cord disorders (lower back pain, sciatica, herniated disc, stiff neck) | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| c. | Arthritis and / or rheumatism (e.g. hip, knee, shoulder, hands) | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| d. | Heart disease and / or vascular disorders (e.g. hypertension, angina / chest pain, heart attack, heart rhythm abnormalities, aneurysm) | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| e. | Diseases of the esophagus, stomach, intestines, liver, pancreas (e.g., stomach ulcers, Crohn's disease, ulcerative colitis) | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| f. | Urinary problems (ex : renal colic, testicular or prostate disorders , bladder or kidney problems, polyp) | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| g. | A trauma, disease or illness requiring regular medical care and / or regular medical treatment | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

| | | | | | | |
|---|---|---|---|---|---|---|
| 11 | Have you ever performed a serological screening test as follows: *If yes, kindly specify the result in the table below.* | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| a. | Hepatitis B virus (HBV)? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| b. | Hepatitis C (HCV)? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| c. | HIV (AIDS)? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 12 | Have you ever had addiction problems related to alcohol and / or drugs? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 13 | Within the next 6 months following the effective date of your contract, do you think you may : | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| a. | Go to see a doctor or require any medical test (e.g. laboratory, imaging and endoscopy) and / or see a specialist and / or seek medical or surgical treatment? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| b. | Receive hospital treatment? (e.g. removal of tonsils, removal of a cyst, removal of a mole) | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

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# CARE & HEALTH

# YOUR LIFE INSURANCE DECLARATION FORM

Henner™

*Please complete the following health declaration for yourself if you apply for the Life Insurance coverage.*

| | | Main Insured |
|---|---|---|
| 14 | Do you suffer from a handicap, disability or chronic illness? | ☐ Yes ☐ No |
| 15 | In the 12 months preceding the effective date of your contract, have you taken sick leave more than 3 times? | ☐ Yes ☐ No |
| 16 | Do you or anyone in your family have a history of the following diseases? Heart disease, vascular, neurological, psychiatric, cancer, diabetes? | ☐ Yes ☐ No |
| 17 | Are you currently on sick leave? | ☐ Yes ☐ No |
| 18 | Have you been declared disabled?<br>Are you in the process of being declared disabled? | ☐ Yes ☐ No<br>☐ Yes ☐ No |
| 19 | Are you currently insured for health or life insurance?<br>Have you ever been refused, restricted or received a premium loading for a previous insurance policy? | ☐ Yes ☐ No<br>☐ Yes ☐ No |
| 20 | Do you fly in a private or aviation club aircraft as a passenger or pilot (excluding regular commercial aircrafts)? | ☐ Yes ☐ No |
| 21 | Have you suffered any medical condition other than those mentioned above? | ☐ Yes ☐ No |
| 22 | Please add any other information regarding your health status that we should know: | |

# CARE & HEALTH

## HEALTH DECLARATION

*If you answered "yes" to any of the above questions, kindly clarify the details in the table below.*

| | Question number | Date of declaration of the first symptoms | Date of the last symptoms | Treatments, tests and results | Complementary precisions |
|---|---|---|---|---|---|
| **Main insured** | | | | | |
| **Spouse** | | | | | |
| **Child 1** | | | | | |
| **Child 2** | | | | | |
| **Child 3** | | | | | |

## DECLARATION AND AUTHORIZATION

1. To ensure medical confidentiality, you must submit this questionnaire and any medical documents sealed and marked confidential, addressed to the attention of the medical board of Henner – GMC:

   Medical board (Care & Health Application)
   Henner - GMC Services Asia Pacific Pte Ltd,
   137 Telok Ayer Street #07-01/02/03, Singapore 068602
   health.declaration@henner.com

2. Please provide your answer on a separate piece of paper and attach it to this Declaration when sending if you need more space to provide your response. If you are applying with more than 3 children, please complete a second form for the additional children.

3. I certify that the statements above are complete, accurate and truthful and agree to provide the medical board of Henner - GMC all the medical information that they need. Any misrepresentation or omission shall render the policy null and void and the premiums paid will be retained by the insurer as damages. The Insured and his dependents will have to refund the benefits they have received.

Please tick the box if you want your intermediary (if any) to be your official representative for medical questions:

☐ I, the undersigned, authorize the Medical Advisory Board or the insurer to provide and request to my intermediary any medical information that is required.

Your email (compulsory): .....

Signed in (City, Country): .....

Date (dd/mm/yyyy): .....

Signature(s) of the Insured and all dependants who have reached majority with the mention "read and approved":



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