| Issue by:<br>Date: |
|---|

**(To be completed by Life Assured)**

**Full Name : _____Policy No (s): _____**

**Occupation : _____NRIC No : _____**

**Address : _____**

_____

**Please tick accordingly.**

☐ **Full Blown AIDS**

Clinical manifestation of AIDS ( Acquired Immune Deficiency Syndrome ) , which must be supported by the results of a positive HIV ( Human Immunodeficiency Virus ) antibody test and a confirmatory Western Blot test. In addition, the Life Assured must have a CD4 cell count of less than 200 and evidence of opportunistic infection and / or AIDS related tumours.

☐ **Occupational Acquired HIV Infection**

The Life Assured being infected by HIV (Human Immunodeficiency Virus) unequivocally as a result of an accident occurring during the course of carrying out normal occupational duties, with sero-conversion to HIV infection occurring within six (6) months of the accident. Any accident giving rise to a potential claim must be reported to the Company within thirty (30) days of the accident taking place and supported by a negative HIV test taken in Malaysia, Singapore or Brunei within seven (7) days of the accident .Infection in any other manner is specifically excluded.

☐ **HIV Infection from Blood Transfusion**

The Life Assured being infected by Human Immunodeficiency Virus or Acquired Immune Deficiency Syndrome provided that:
(a) the infection is due to a blood transfusion received in Malaysia, Singapore or Brunei;
(b) the Company, on the advice of the Medical Adviser appointed by the Company is fully satisfied that the infection was due to a blood transfusion given as part of medical treatment after commencement of the Policy;
(c) the infected Life Assured is not a haemophiliac; and
(d) the conditions must be life threatening and there exists no known cure.

1. **Nature of Claim and Related Details**

a) Describe fully the symptoms for which you consulted a medical practitioner.

_____

b) How long did you have the symptoms before you consulted a medical practitioner?

_____

c) Date when you FIRST consulted a medical practitioner. Please note the name/ address of the doctor.

_____

d) Please state the date you received the diagnosis of being HIV positive:

_____

e) Have you previously suffered from, or received treatment for, a similar or related illness?
If 'yes', please give full details:

_____

2 **Lifestyle**

a) Have you been rejected as a blood donor or organ donor? Please give details if 'yes' (i.e. reason).

_____

b) Have you ever received a blood transfusion or a blood product? If yes, please give details (i.e. reason, date etc).

_____

c) Did you inject yourself or have you been injected with any drugs which have <u>not</u> been prescribed by a medical practitioner. Please give details if 'yes'.

_____

d) Have you been tested, received medical advice or treatment in connection with any sexually transmitted (venereal) disease or Hepatitis B or C. Please give details if 'yes'.

_____

e) Do you or have you belonged or been associated with any of the following groups: (Please tick accordingly.)

- ☐ i)Homosexuals
- ☐ ii)Bisexuals
- ☐ iii)Intravenous (IV) drug users
- ☐ iv)Haemophiliacs
- ☐ v)Multiple sexual partners
- ☐ vi)Prostitutes
- ☐ vii)Sexual partners of any of the groups

f) If you have indicated one or more of the above in (e), please state when, how long and how many partners.

_____

g) If you have indicated (iii) in question 2(e), please state when the last time you used the IV drug was.

_____

3. **For Occupationally acquired HIV infection only:**

a) Please provide details and date of accident. _____

b) Please state the nature of your occupation at the time of the accident.

_____

c) Have you had any needle prick injuries before? _____

d) Please provide us the negative HIV test result done within 30 days of accident.

e) Please state the name of the witness to the accident, if any.

_____

4. **For HIV Infection from Blood Transfusion only:**

a) Are you a haemophiliac?

_____

b) Did you or do you have any other conditions that require transfusion of blood or blood product?

_____

5. Are you currently on any follow up or treatment? If yes, please provide the details of the doctors/ specialists who have been consulted in connection with your condition.

   Name :
   Address :
   Date(s) of consultations :

6. If you have or are receiving treatment at a hospital or any other institution please supply the following details.

   Name of hospital or institution :
   Date of admission :

7. Please provide the name and address of your usual medical attendant if different from the above.

_____

Signed _____ Date_____
Signature of the Life Assured

Signed _____ Date _____
Signature of Assured
(if Assured and Life Assured are different persons)