Dependent Health Declaration Form

CLEAR FORM | CLICK TO SUBMIT

INSTRUCTIONS: Please complete, save and email (Click to Submit) to: application.cghbAP@cigna.com

Personal Particulars	Last Name	First Name	Date of Birth (DD/MM/YYYY)	Gender	Height ☐ cm ☐ f/in	Weight ☐ kg ☐ lbs ☐ st
Family Member				☐ M ☐ F		

Employee Name Employer Group Name

Has this dependent ever suffered from, or received medical advice or treatment for the following condition(s)? If yes, please complete the following question(s):

☐ Cancer Year of Onset? Type of Cancer? Ever Spread to Other Organs?
Stage of Cancer? (if known) Type of Treatment Received?
Completion Date Of Last Treatment? Are You Fully Recovered? ☐Yes ☐No Any Complications?

☐ Brain Disorder or Stroke Year of Onset? What is/was the Exact Diagnosis?
Type of Treatment Received? Any Impact on Performing Daily Activities After Treatment? ☐Yes ☐No

☐ Heart Attack or Heart Disease / Disorder Year of Onset?
What is/was the Exact Diagnosis? Ability to Exercise Resumed Normal Now? ☐ Yes ☐ No

☐ Hepatitis (Except Hepatitis A or E) or Liver Disease Year of Onset? What is/was the Exact Diagnosis?
Any treatment received? If yes, please also state the type of treatment received?
Current Liver Function Resumed Normal? ☐Yes ☐No Are You Fully Recovered? ☐ Yes ☐No Any Complications?

☐ Diabetes Year of Onset? Duration? What is Your Current HbA1c? Any Complications?

☐ High Blood Pressure Year of Onset? What is Your Current Blood Pressure Level? Any Complications?

☐ High Cholesterol Year of Onset? What is Your Current Lipid Level Any Complications?

☐ Lung Disease Year of Onset? What is/was Exact Diagnosis? Any Impact on Performing Daily Activities?

☐ Kidney Disease Year of Onset? What is/was Exact Diagnosis? Current Renal Function Resumed Normal? ☐Yes ☐No
Any Impact on Performing Daily Activities?

☐ AIDS/HIV Infection

☐ Currently Pregnant (For Female Aged 16 or Above)

Apart from those reported medical conditions, during the past three years have you experienced symptoms of a medical condition or been diagnosed with a medical condition that required treatment or medication for more than 1 months or ongoing review of monitoring by a specialist or doctor?

Condition or Diagnosis Onset Date?
Type of Investigation and/or Treatment Done? Date of Investigation/Treatment?
Results of Investigation/Treatment? Are You Fully Recovered? ☐Yes ☐No Any Complications?

Apart from those reported medical conditions, are you currently waiting to undergo any form of medical treatment or any investigations or waiting for the results of a test (apart from routine checkups)?

Condition or Diagnosis Onset Date?
Type of Treatment to be Done? Date of Treatment to be Done?

Data Protection As Data Controller, we will process, disclose, use, store and retain all your personal and sensitive information in accordance with relevant data protection legislation. We will process your personal and sensitive information to allow us to carry out our obligations under this plan. From time to time we may share this information with other insurers to help us to detect and prevent fraud. Telephone calls to and from our organisation may be recorded for the purposes of quality and training. Your application for cover and any future claims made under this plan may also include sensitive medical information. This will be kept confidential and only disclosed to authorised individuals.

Declaration: I declare that the answers I have given are to the best of my knowledge and belief, true and complete. I have not withheld any material fact. A material fact is one which Cigna may want to take into account when considering my application.

Signature	Date: (MM/DD/YYYY)

Please input any additional details below.