Insurance Health Risk Assessment Declaration

Full Name

Date of Birth

Address

Contact Number

Email

Health Declaration

1. Do you have any of the following conditions? (select all that apply)

- [ ] Diabetes
- [ ] Hypertension
- [ ] Heart Disease
- [ ] Respiratory Issues
- [ ] Other

If "Other", please specify

2. Are you currently taking any medication?

- ○ Yes
- ○ No

If yes, please specify

3. Do you have any allergies?

- ○ Yes
- ○ No

If yes, please specify

4. Have you had any major surgery in the past 5 years?

- ○ Yes
- ○ No

If yes, please provide details

5. Family history of genetic/serious illnesses (specify relationship and illness)

Lifestyle Information

6. Do you smoke?

- Yes
- No

7. Do you consume alcohol?

- Yes
- No

8. Exercise frequency (per week)

Declaration & Acknowledgement

I hereby declare that the information provided above is true and correct to the best of my knowledge.

Signature

Date