COVID-19 (Coronavirus) Exposure Questionnaire

Life Insured Name : _____

Application Number: _____

Part 1 – Applicable for all applicants

Please answer the following questions with as much detail as possible:

Q No	Question	Answer
1	Have you experienced any of the following symptoms within the last 14 days? • Fever (Greater than 38C or 100.4 F) • Cough • Shortness of breath • Malaise (flu-like tiredness) • Rhinorrhoea (mucus discharge from the nose) • Sore throat • Gastro-intestinal symptoms such as nausea, vomiting and/or diarrhoea If yes, to any of these, please indicate which and provide full information._____	☐Yes ☐ No
2.	Have you been advised to be tested to rule in, or rule out, a diagnosis of novel coronavirus (SARSCoV-2/COVID-19)? Or, are you awaiting the result of a test which has already been submitted for the novel coronavirus (SARS-CoV-2/COVID-19)?	☐Yes ☐ No
3	Have you ever tested positive for the novel coronavirus (SARS-CoV-2/COVID-19)? If yes, provide the date of positive diagnosis._____	☐Yes ☐ No
4	Are you, or have you been in close contact with anyone who has been quarantined or who has been diagnosed with novel coronavirus (SARS-CoV-2/COVID-19) ? If yes, please provide details_____	☐Yes ☐ No
5.	Have you ever been quarantined due to a possible exposure to novel coronavirus (SARSCoV2/COVID-19)? If yes, please provide dates and locations _____	☐Yes ☐ No
6	Are you currently in good health?	☐Yes ☐ No

7. Travel Declaration:

a. Please provide your travel patterns over the past 14 days:

COUNTRY	CITY	DATE ARRIVED	DATE DEPARTED

b. Please detail your intended future travel plans for the next 30 days:

COUNTRY	CITY	DATE ARRIVAL	INTENDED DURATION

Part 2: Applicable to Health care workers [Doctors, Nurses, Paramedics, Pharmacist; Person associated with Healthcare]

Sr No	Question	Answer
1	Occupation	
2	Medical Specialty (if applicable)	
3	Exact nature of duties (including procedural or non-procedural duties)	
4	Name and address of the healthcare facility or facilities in which you work.	
5	Name of the Health Authority under which you are registered.	
6	Does your healthcare facility have sufficient personal protective equipment (PPE) to provide to its workforce?	

I confirm that the answers I have given are, to the best of my knowledge, true, and that I have not withheld any material information that may influence the assessment or acceptance of this application.
I agree that this form will constitute part of my application for insurance(s) and that failure to disclose any material fact known to me may invalidate my insurance(s).

_____

Signature of Life Insured / Proposer.

Date : _____
Place : _____

ABSLI/UW/ COVID/ Marc 2020/Ver1.2