



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? <ul style="list-style-type: none"> • 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. _____	<input type="checkbox"/> Yes <input type="checkbox"/> 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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3	Have you ever tested positive for the novel coronavirus (SARS-CoV-2/COVID-19)? If yes, provide the date of positive diagnosis. _____	<input type="checkbox"/> Yes <input type="checkbox"/> 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 _____	<input type="checkbox"/> Yes <input type="checkbox"/> 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 _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
6	Are you currently in good health?	<input type="checkbox"/> Yes <input type="checkbox"/> 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

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