COVID-19 (CORONAVIRUS) EXPOSURE QUESTIONNAIRE

Reset Form

Name of Life Insured	Policy number

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

1. Have you (or the child insured) experienced any of the following symptoms within the last 14 days? ◯ yes ◯ no

- Fever
- Cough
- Shortness of breath
- Malaise (flu-like tiredness)
- Rhinorrhea (runny nose)
- Sore throat
- Gastro-intestinal symptoms such as nausea, vomiting and/or diarrhea
- Loss of taste or smell

If yes, have you (or the child insured) had a negative Covid-19 test for these symptoms? ◯ yes ◯ no

Please provide details of all symptoms and date last experienced:

2. Within the last 14 days, have you (or the child insured) had close contact with anyone who has or has had symptoms of Covid-19?
◯ yes ◯ no - if yes, please provide details including date of contact, circumstances, any symptoms experienced:

3. Have you (or the child insured) ever tested positive for or been told you had Covid-19? ◯ yes ◯ no
If yes, were you (or the child insured) admitted to hospital or did you spend time in the ER? ◯ yes ◯ no
If yes, provide date of test, date and duration of hospital admission/ER visit, and date and details of last symptoms:

4. Do you (or the child insured) have any residual symptoms or complications related to Covid-19 or a suspected Covid-19 infection?
Or have you (or the child insured) been told or suspect that you have long Covid or post-Covid syndrome? ◯ yes ◯ no
If yes, please provide details:

DECLARATION

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 (or parent/guardian) **X**	Signed at	Date

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