COVID-19 Questionnaire – This questionnaire should be completed by the applicant.

Application Number: ……

Full name of the proposed participant: ……..

Date of birth: ……..

PLEASE ANSWER FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

1. Do you currently have or have you had any of the following **symptoms** in the past 14 days?
   - Fever
   - Sore throat
   - Dry cough
   - Myalgia/arthralgia
   - Headache
   - Shortness of breath
   - Fatigue
   - Dysgeusia (distortion of the sense of taste)
   - Anosmia (loss of the sense of smell)

   If yes, please provide further details i.e. dates, duration, treatment, results of investigations (if any), name and address of treating doctor/clinic/hospital.

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2. Have you been tested for Covid-19? Yes No

   If Yes: Date of the test: ……

   Result of the test:

   - Covid-19 positive
   - Covid-19 negative

   Have you made a complete recovery with no sequelae? Yes No

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3. Within the past 14 days have you had any contact with someone confirmed as infected with the virus ? Yes No

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4. Have you been issued any notice or directive to self-quarantine or stay home (excluding as part of altered employment arrangement) ? Yes No

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COVID-19 Questionnaire – This questionnaire should be completed by the applicant.

5. Are you currently residing outside your usual country of residence or have you returned to your usual country of residence within the last 4 weeks? Yes No

   If yes, please provide information: Country / City / Departure Date / Arrived Date / Planned return date.

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6. In the next three months, do you intend to travel outside your usual country of residence ? Yes No

   If yes, please provide information: Country / City / Date of Travel / Intended Duration

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I hereby declare that the foregoing statements and answers are true and that no fact has been withheld. I agree that they shall constitute part of my application for life assurance. I understand and accept that failure to disclose a fact or giving false information may invalidate the contract or may result in non-payment of a claim.

Date : …….. Place : …….

Signature of proposed participant: