COVID-19 Questionnaire

To be completed by the person to be insured

General Instructions

The information you provide on this form will assist with considering your application for insurance.

- Please complete all of the questions of this form using blue or black ink.
- It is important to sign and date the form after you complete all questions.
- Any inaccuracies or misleading information on this questionnaire could affect your coverage and result in non-payment of a future claim.

Personal Details

Your surname: ______________________________

Given names: ______________________________

Date of birth: ______________________________

Application number: ______________________________

Medical Details

1. Have you been to a strongly COVID-19 affected location, area, region or country during the last 3 weeks? ☐ Yes ☐ No

   If yes, please advise precise location/-s:

   ____

   Reason for stay (e.g. place of residence, work, travel):

   ____

   For temporary stay/-s, please advise precise date/-s and duration/-s:

   ____

2. Do you plan to travel to a strongly COVID-19 affected area, region or country? ☐ Yes ☐ No

   If yes, please advise precise location/-s:

   ____

Reason for stay (e.g. place of residence, work, travel):

____

For temporary stay/-s, please advise precise date/-s and duration/-s:

____

3. Within the last 3 weeks, did you have close contact with a confirmed or suspected COVID-19 infected person? ☐ Yes ☐ No

If yes, what measures resulted from this?

____

Date and duration of measure, if any (from/to):

____

Reason for termination of measure taken, if applicable:

____

4. Within the past 3 weeks, were you quarantined or have you been advised to self-isolate at home (by authorities/officials, a health care provider, medical staff or a medical advisor or by any other institution) or have you decided on your own to self-isolate yourself? ☐ Yes ☐ No

If yes, please advise about the reason for quarantine or self-isolation:

____

Date/-s (from/to)

____

Reason for termination:

____

5. Have you been investigated for, diagnosed with or suspected to have COVID-19? ☐ Yes ☐ No

Please advise in detail on all examinations, attach extra sheet if necessary:

Date: ☐ COVID-19 confirmed ☐ COVID-19 not confirmed

Type, reason and result of examination: ______________________________

Date: ☐ COVID-19 confirmed ☐ COVID-19 not confirmed

Type, reason and result of examination: ______________________________

Date: ☐ COVID-19 confirmed ☐ COVID-19 not confirmed

Type, reason and result of examination: ______________________________

6. Is a COVID-19 investigation/test planned or recommended for you? ☐ Yes ☐ No

7. Have you been admitted to a hospital (or to any other kind of medical or public health institution/unit) whilst you have/had a COVID-19 infection or whilst you are/were suspected to have a possible COVID-19 infection? ☐ Yes ☐ No

   If yes, please advise name and address of hospital/institution/unit:

   ____

   ____

   Dates of admission and discharge:

   ____

   Please attach discharge report/-s.

8. Do you currently suffer or did you suffer during the last 4 weeks from any of the following symptoms:

   ☐ Sore throat
   ☐ Cough
   ☐ Runny nose or nasal discharge
   ☐ Body aches
   ☐ Tiredness or weakness
   ☐ Shortness of breath or difficulty breathing
   ☐ None of the above
   ☐ Fever of 38°C or above
   ☐ Flu-like symptoms, chills
   ☐ Nausea
   ☐ Vomiting
   ☐ Diarrhea
   ☐ Diminished or lost sense of smell or taste

   From when until when did you suffer from the mentioned symptoms? Dates (from/to):

   ____

   ____

9. Who is your family doctor or which doctor/clinic can best provide information about your state of health? Please provide name and address:

   ____

   ____

10. Please enclose all medical and diagnostic reports for COVID-19 infection and for other diseases, if any.

11. Number of attached extra pages (medical reports, laboratory findings, test results etc.): ______

I hereby declare that the information provided above is true and accurate.

____

Place, Date Signature of the person to be insured