COVID-19 (Corona virus) Exposure Questionnaire

Application number	Nominee Name
Name of Life insured	Nominee DOB
Date of Birth	Type of ID
Gender	ID number
Contact number/Date/Time of Tele interview	

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

1.Are you, or have you been in close contact with an individual confirmed /suspected to have COVID-19/SARS CoV2 OR currently residing abroad/travelled abroad post 1st Jan 2020 OR do you have plan to travel overseas in upcoming 6 months, if yes then pls give details below

Country/City	Duration of stay	Date Arrival in India/Date of intended travel	Date Departed/Indented duration

Details_____

2. On your return to India if you were advised to be quarantine/Isolated for COVID-19 / advised to self-isolate without symptoms (e.g. contact tracing) due to SARS-CoV-2/COVID-19/ isolation by health authority due to COVID (excluding mandatory government orders to remain at home), or Community quarantine/ had a positive COVID-19/ SARS-CoV-2 antibody test (a test for the immune response produced by the body in response to a previous infection)

Yes ☐ No ☑

If yes, when did your self-isolation end?_____

a) In the last 3 months have you or your family ,have been advised to be tested to rule in, Or rule out, a diagnosis of SARS-CoV-2/COVID-19/ have you ever had a positive COVID-19/ SARS-CoV-2 antigen test (a test for the presence of the virus in the body)/Or, are you awaiting the result of a test which has already been submitted for the COVID-19/ SARS-CoV-2

b) Have you/family member had symptoms of COVID-19 (i.e. persistent cough, shortness of breath/fever/rinohrrea/sore throat /malaise/Gastro-intestinal symptoms such as nausea, vomiting and/or diarrhea etc.), or have you self-isolated with symptoms on medical advice?

C) If yes then provide details

- When was this?
- Did you require admission to hospital?
- If yes, did you require a stay in High-dependency unit (HDU), intensive care unit (ICU), intensive treatment unit (ITU) or critical care unit (CCU) admission?

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- If yes, did you require the support of a ventilator?

Yes ☐ No ☐

Details _____

If yes to (b) or (c), have you made a full physical function recovery, able to perform your normal occupational or daily duties, without any ongoing symptoms or restrictions (i.e. shortness of breath or fatigue)?
If so, when did you make a full recovery? Please share details _____

COVID-19 (Coronavirus) Exposure Questionnaire for Health Care Workers[1]

(Please acknowledge in addition to questions mentioned above)

Occupation	
Medical Specialty (if applicable)	
Exact nature of duties (including procedural or non-procedural duties)	
Name and address of the healthcare facility or facilities in which you work.	
Name of the Health Authority under which you are registered.	
Does your healthcare facility have sufficient personal protective equipment (PPE) to provide to its workforce?	

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

1. Have you been or do your work duties involve 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 including nature of work for patients with novel coronavirus (SARS-CoV-2/COVID-19).

Yes ☐ No ☑

2. Have you ever been on voluntary leave, or placed on compulsory leave of absence/sick leave, due to a possible exposure to novel coronavirus (SARS-CoV-2/COVID-19)? If yes, please provide relevant dates and details_____

Yes ☐ No ☑

[1] *Health care Workers shall mean all registered health care professionals (doctors, nurses, allied health professionals including physiotherapists, pharmacists, phlebotomists etc.) involved in direct patient care*

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Are you currently in good health?, If No, please share details_____

Yes ☑ No ☐

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).

KAMAL GUNASEKARAN	☐	29 / 01 / 2022
Name	Signature	Date