

## Supplementary Health Questionnaire

**Proposed Insured:** \_\_\_\_\_

**Applicant Payor:** \_\_\_\_\_

1. Since March 16, 2020, your work set-up is (Check if applicable, may be more than 1)  
☐ Work from Home  
☐ Reporting in workplace  
☐ Others, please specify \_\_\_\_\_
2. Have you had any known exposure to persons with Confirmed, Probable or Suspected case of COVID-19?  
**Yes** ☐ **No** ☐  
If yes, please state relationship to patient \_\_\_\_\_

Exposure thru (check all applicable):

- ☐ Lives in the same household ☐ Informed thru contact tracing  
☐ Thru work ☐ Others, please specify \_\_\_\_\_

3. Have you been advised or diagnosed to be a Confirmed, Probable or Suspected case of COVID-19? **Yes** ☐ **No** ☐

If yes, have you been cleared of by a certified medical practitioner from being a Confirmed, Probable or Suspected case of COVID-19? Please attach supporting document.

4. Have you had any history of travel abroad (for the last six months) to countries with confirmed case/s of COVID-19?

	Name of Country	Departure Date	Return Date
1			
2			
3			
4			
5			

If there was a travel within the last 6 months, the last date of arrival in the Philippines was on \_\_\_\_\_.

5. Had fever, cough, colds, sore throat, fatigue, weakness, muscle pain, shortness of breath in the last 30 days? Please underline applicable item and give details. \_\_\_\_\_

\_\_\_\_\_

Signature of Applicant / Payor \_\_\_\_\_

Date \_\_\_\_\_

Signature of Proposed insured \_\_\_\_\_

Date \_\_\_\_\_