



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):

- | | |
|--|---|
| <input type="checkbox"/> Lives in the same household
<input type="checkbox"/> Thru work | <input type="checkbox"/> Informed thru contact tracing
<input type="checkbox"/> 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 _____