

COVID-19 (Coronavirus) Exposure Questionnaire

1. Are you, or your family have you been in 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.

Yes ☐ No ☐

2. Are you, or your family have you ever been serving a notice of quarantine in any form imposed by local health authorities or government or airport authority for possible exposure to novel coronavirus (SARS-CoV-2/COVID-19)? If yes, please provide more details like location, dates, quarantine period.

Yes ☐ No ☐

3. Have you been advised to be tested to rule in, or rule out, a diagnosis of novel coronavirus (SARS-CoV-2/COVID-19)? Or, are you awaiting the result of a test which has already been submitted for the novel coronavirus (SARS-CoV-2/COVID-19)?

Yes ☐ No ☐

4. Have you ever tested positive for the novel coronavirus (SARS-CoV-2/COVID-19)? If yes, provide the date of positive diagnosis. And also details of subsequent tests

Yes ☐ No ☐

5. Have you experienced any of the following symptoms within the last 14 days?

- Any fever
- Cough
- Shortness of breath
- Malaise (flu-like tiredness)
- Rhinorrhea (mucus discharge from the nose)
- Sore throat
- Gastro-intestinal symptoms such as nausea, vomiting and/or diarrhea

Yes ☐ No ☐

If yes, to any of these, please indicate which and provide full information.

6. Are you a Healthcare professional (Include for instance General Practitioners, Doctors, Hospital Doctors, Surgeons, Therapists, Nurses, Pathologist, paramedics, Pharmacist, Ward helpers, Individuals working in Hospitals/ Clinics having novel coronavirus (SARS-CoV-2/COVID-19)

Ward ? if yes , please provide details whether working in Hospital with Covid-19 ward or treating or in contact with Covid19 infected individuals.

Yes ☐ No ☐

7. If Q6 is Yes , please provide more details in terms of daily duties including details whether enrolled as Corona virus warrior or working in Hospital/ clinic with novel coronavirus (SARS-CoV-2/COVID-19) ward/unit or treating/ in contact with SARS-CoV-2/COVID-19 infected individuals.

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8. TravelDeclaration

- a. Are you currently residing outside of India?
Yes ☐ No ☐

If Yes, Please provide your details:

COUNTRY	CITY	DATE of TRAVEL	INTENDED DURATION

- b. Have you travelled abroad in the past 14 days?
Yes ☐ No ☐

If Yes, Please provide your travel details over the past 14days:

COUNTRY	CITY	DATE ARRIVED	DATE DEPARTED

- c. Do you intend to travel abroad in next 3 months:
Yes ☐ No ☐

If Yes, Please provide details of your intended future travel within next 3 months:

COUNTRY	CITY	DATE of TRAVEL	INTENDED DURATION

9. COVID19 Vaccination details

Have you been vaccinated for COVID19?

Yes ☐ No ☐

If Yes,

- Date of administration of the first dose _____
- Date of administration of the second dose _____
- Name of vaccine _____
- Have you experienced any adverse reaction post vaccination ? Yes /No

If yes, please share details including treatment taken for the same and date of complete recovery

Clients to share Copy of vaccination certificate (or copy of any official documentation confirming complete vaccination & issued by the relevant health authority)

Please note self-declarations are not acceptable.

Declaration

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).

Signed at _____ on this day _____ of _____, _____

Applicant Signature