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**COVID-19 RECOVERY QUESTIONNAIRE– APPLICANT**

(This questionnaire will form part of the application)

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| --- | --- | --- | --- | --- | --- |
| **First Name:** |  | | **Last Name:** |  | |
| **Date of Birth** (mm/dd/yyyy): | |  | **Policy/Application No.:** | |  |

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| 1. On what date were you diagnosed with SARS-CoV-2/COVID-19? | | | | | | | |  | | | | |
| 1. What type of test was used to make the diagnosis? | | | | | | | | | | | | |
|  | RT-PCR test (performed with a nasal and throat swab) | | | | | | | | | | | |
|  | Antibody test (performed with a finger prick or blood test) | | | | | | | | | | | |
|  | I do not know | | | | | | | | | | | |
| 3. Did you receive a printed or electronic report with your test result? If yes, please submit a copy together with this questionnaire. | | | | | | | | | | | | Yes  No |
| 1. Why did you receive a COVID-19 test? | | | | | | | | | | | | |
|  | Had symptoms/was ill | | | | | | | | | | | |
|  | Had exposure to someone with known COVID-19 infection, but had no symptoms | | | | | | | | | | | |
|  | As part of a general screening/testing program, but had no symptoms | | | | | | | | | | | |
|  | Others (please provide details): | | | | | | | | | | | |
| 1. At any time did you require admission to hospital for observation, quarantine or treatment of COVID-19? | | | | | | | | | | | | |
| If **Yes** , please answer 5.1 to 5.5 | | | | No | | | | | | | | |
| 5.1 Was admission for observation or quarantine purposes only and at no time did you have symptoms and/or required treatment? | | | | | | | | | | | | |
| Yes (Please provide details below.)  No | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| 5.2 Date of admission | |  | | | | Date of discharge | | | | |  | |
| 5.3 Did you require treatment in the intensive care unit (ICU)? | | | | | | | | | Yes  No | | | |
| 5.4 Did you require a machine to help you breathe? | | | | | | | | | Yes  No | | | |
| 5.5 Did you experience complications such as lung (respiratory), kidney, liver or heart problems related to the COVID-19 infection? | | | | | | | | | | | | |
| Yes (Please provide details below.)  No | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| 1. What symptoms do you have at this time? | | | | | | | | | | | | |
| Fatigue or loss of energy | | | Fever | | | | | | | Body ache | | |
| Concentration difficulties | | | Cough | | | | | | | Headaches | | |
| Shortness of breath | | | Depressed mood | | | | | | | No symptoms | | |
| 1. Date on which you experienced complete recovery | | | | |  | | | | | | | |
| 1. Do you have pending or recommended follow-up appointments or tests related to your COVID-19 diagnosis? | | | | | | | Yes (Please list dates and test.)  No | | | | | |
|  | | | | | | | | | | | | |

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| 1. If employed, have you been certified to return to work on an unrestricted and full capacity basis? | Yes  No (Please provide details below.) |
|  | |
| 1. Please provide any additional information that you feel is important. | |
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| **DECLARATION** |
|  |
| **I confirm that the answers I have given are, to the best of my knowledge, true and correct 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 and that failure to disclose any material fact known to me may invalidate my insurance. Furthermore, I understand that declaration of any untruthful statement may also be a ground to invalidate my insurance.** |

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| --- | --- |
| **Name:** |  |

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| **Signature:** |  |

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| **Date of Signing:** |  |

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