

**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?
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| [ ]  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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|       |

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| **DECLARATION** |
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| **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:** |       |

