Life Insurance

Aditya Birla Sun Life Insurance Company Limited
(A subsidiary of Aditya Birla Capital Ltd.)

ADITYA BIRLA CAPITAL
PROTECTING INVESTING FINANCING ADVISING

COVID-19 (Coronavirus) Exposure Questionnaire

Life Insured Name : _____

Application Number : _____

Part 1 – Applicable for all applicants

Please answer the following questions with as much detail as possible

Q. No.	Question	Answer
1.	Have you experienced any of the following symptoms within the last 14 days? • Fever (Greater than 38C or 100.4 F) • Cough • Shortness of breath • Malaise (flu-like tiredness) • Rhinorrhoea (mucus discharge from the nose) • Sore throat • Gastro-intestinal symptoms such as nausea, vomiting and/or diarrhoea If yes, to any of these, please indicate which and provide full information. _____	☐ Yes ☐ No
2.	Have you been advised to be tested to rule in, or rule out, a diagnosis of novel coronavirus (SARSCoV2/COVID-19)? Or, are you awaiting the result of a test which has already been submitted for the novel coronavirus (SARSCoV2/COVID-19)?	☐ Yes ☐ No
3.	Have you ever tested positive for the novel coronavirus (SARSCoV2/COVID-19)? If yes, provide the date of positive diagnosis. _____	☐ Yes ☐ No
4.	Are you, or have you been in close contact with anyone who has been quarantined or who has been diagnosed with novel coronavirus (SARSCoV2/COVID-19)? If yes, please provide details _____	☐ Yes ☐ No
5.	Have you or your family member ever been quarantined due to a possible exposure to novel coronavirus (SARSCoV2/COVID-19)? If yes, please provide dates and locations _____	☐ Yes ☐ No
6.	Are you currently in good health and able to work full time or carry out daily normal activities?	☐ Yes ☐ No

7. Travel Declaration:

a. Please provide your travel patterns over the past 14 days:

COUNTRY	CITY	DATE ARRIVED	DATE DEPARTED

b. Please detail your intended future travel plans for the next 30 days:

COUNTRY	CITY	DATE ARRIVAL	INTENDED DURATION

Part 2 - COVID Vaccination details:

Sr. No.	Question	Answer
1	Have you been vaccinated for COVID-19? If Yes answer below Q2-5.	☐ Yes ☐ No
2	Date of administration of the first dose	
3	Date of administration of the second dose	
4	Name of vaccine	
5	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	

In case vaccination is done, copy of vaccination certificate (or copy of any official documentation confirming complete vaccination & issued by the relevant health authority) is required.

Part 3 - Applicable to Healthcare workers [Doctors, Nurses, Paramedics, Pharmacist; Person associated with Healthcare]

Sr. No.	Question	Answer
1	Occupation	
2	Medical Specialty (if applicable)	
3	Exact nature of duties (including procedural or non-procedural duties)	
4	Name and address of the healthcare facility or facilities in which you work.	
5	Name of the Health Authority under which you are registered.	
6	Does your healthcare facility have sufficient personal protective equipment (PPE) to provide to its workforce?	☐ Yes ☐ No
7	Are you working in a Hospital with a Covid-19 ward or treating or in contact with Covid-19 infected individuals. If Yes, please provide details.	☐ Yes ☐ No

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).

Date : _____

_____

Signature of Life Insured/Proposer.

Place : _____

COVID-19 Recovery Questionnaire

(To be filled by applicant who has been diagnosed and recovered from Covid 19)

1. On what date were you diagnosed with SARSCoV2/COVID-19?

   _____

   _____

2. What type of test was used to make the diagnosis? (circle one)
   a) rt-PCR test (usually performed with a nasal and throat swab)
   b) Antibody test (usually performed with a finger prick or blood test)
   c) I do not know

3. Did you receive a printed or electronic report with your test result? If yes, please return a copy with this questionnaire.

   ☐ Yes ☐ No

4. Why did you receive a COVID-19 test? (circle one)
   a) Had symptoms/was ill
   b) Had exposure to someone with known COVID-19 infection, but had no symptoms
   c) As part of a general screening/testing program, but had no symptoms
   d) Other (please provide details)

   _____

   _____

5. At any time did you require admission to a hospital for observation, quarantine, or treatment of COVID-19?

   ☐ Yes ☐ No

   If yes, please continue:

   a) Was admission for observation or quarantine purposes only and at no time did you have symptoms and/or require treatment?

   ☐ Yes ☐ No

   b) Date of admission? _____ Date of discharge? _____

   c) Did you require treatment in the intensive care unit (ICU)?

   ☐ Yes ☐ No

   d) Did you require a machine to help you breathe?

   ☐ Yes ☐ No

   e) What complications did you experience such as lung (respiratory), kidney, liver, or heart problems related to the COVID-19 infection? (please provide details).

   _____

   _____

   _____

6. What symptoms did you have at that time? (circle all that apply)
   a) Fatigue or loss of energy
   b) Concentration difficulties
   c) Fever
   d) Cough
   e) Body ache
   f) Headaches
   g) Shortness of breath
   h) Depressed mood
   i) No symptoms

7. Date on which you experienced complete recovery:

_____

_____

8. Do you have any pending or recommended follow-up appointments or tests related to your COVID-19 diagnosis?

☐ Yes ☐ No

If yes, please list dates and test:

_____

_____

9. If employed, have you been certified to return to work on an unrestricted and full-capacity basis?

☐ Yes ☐ No

If no, please provide details:

_____

_____

Signed at _____ on this day _____ of _____ , _____

_____	_____	_____
Witness	Signature of Proposed Insured	Signature of Policy Owner