

COVID-19 (Coronavirus) Exposure Questionnaire

Applicant's Name: Application Number:

Please answer the following questions with as much detail as possible:

1. Are you, or 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. Have you ever been quarantined due to a possible exposure to novel coronavirus (SARSCoV2/COVID-19)? If yes, please provide dates and locations.

Yes ☐ No ☐

3. Have you been advised to be tested to rule in, or rule out, a diagnosis of novel coronavirus (SARSCoV-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.

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
☐ None of the above

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

6. Travel Declaration

a. Please provide your travel patterns over the past 14 days: Yes ☐ No ☐

COUNTRY	CITY	DATE ARRIVED	DATE DEPARTED

b. Please detail your intended future travel plans for the next 30 days: Yes ☐ No ☐

COUNTRY	CITY	DATE ARRIVAL	INTENDED DURATION

7. Are you currently in good health?

Yes ☐ No ☐

8. Does your occupation fall within any of the below mentioned? (If yes please provide details)? Doctor/ medical professional? Nursing personnel? Pharmacist? Transport work force personnel? Police/Military staff? Pilots/ Cabin Crew personnel? Merchant marine?. Any other occupation which has higher exposure to a large population. If yes, please specify.

Yes ☐ No ☐

9. Have you been vaccinated?

Yes ☐ No ☐

Vaccination details	Name of vaccine
a. Date of 1st dose	DD/MM/YYYY
b. Date of 2nd dose	DD/MM/YYYY
c. Any Adverse reaction except fever, body aches	Yes ☐ No ☐
If response to question no. 9(c) is yes, please provide details.	

Declaration

☐ I hereby confirm that the answers to the questions provided by me/us are to the best of our knowledge and true. I have not withheld any material fact or information which may affect the assessment or acceptance of this proposal by IndiaFirst Life Insurance Company Ltd. I understand and accept that I will receive all communication including the soft copy of the policy document via email / WhatsApp or in link via SMS from IndiaFirst Life Insurance Company Limited.

Signed at _____ on this day _____ of _____

Applicant Signature