PROMOTED BY

बैंक ऑफ़ बड़ौदा Bank of Baroda | यूनियन बैंक Union Bank of India

IndiaFirst LIFE INSURANCE

Application Number: _____

Name of Life Assured: _____

Part A

COVID-INFECTION QUESTIONNAIRE (TO BE FILLED BY LIFE ASSURED)

1. Date of diagnosis of covid-19 infection | D | D | M | M | Y | Y | Y | Y | ☐ Yes ☐ No

2. Please describe symptoms experienced during covid-19 infection ☐ Yes ☐ No

3. Please confirm nature of illness- ☐ Yes ☐ No
   - ☐ Mild(asymptomatic or did not require hospitalization, oxygen support etc)
   - ☐ Moderate (oxygen support or hospitalization required)
   - ☐ Severe (Hospitalization or critical care support required)

4. Please confirm whether you were ☐ Home quarantined ☐ Isolated ☐ Hospitalized ☐ Yes ☐ No

5. If you were hospitalized, please provide date of Admission | D | D | M | M | Y | Y | Y | Y |, Date of discharge | D | D | M | M | Y | Y | Y | Y | ☐ Yes ☐ No

6. Treatment taken during illness (name of drug, dosage, frequency)- Please share hospitalization documents, discharge summary/consultation papers ☐ Yes ☐ No

7. Please confirm Investigations done during illness (please provide copy of reports). ☐ Yes ☐ No

Part B

POST- COVID FITNESS QUESTIONNAIRE (TO BE FILLED BY LIFE ASSURED)

1. Have you visited any doctor after completion of treatment for covid-19? ☐ Yes ☐ No
   (1) If so, please confirm reason & symptoms at time of doctor visit. Please provide all related documents including consultation papers, investigation, treatment & follow up details _____
   (2) Name of the doctor _____

2. If you were suffering from any chronic illnesses e.g. (diabetes, hypertension, asthma, Bronchitis, TB etc). during or before covid-19? Is the condition worsened after covid-19 illnesses (e.g inadequate blood sugar/blood pressure control, increase in medication dosages etc, addition of any medications etc.). ☐ Yes ☐ No

   If Yes Please provide details _____

3. Do you suffer from any of following (since covid-19 infection):
   - ☐ Chronic fatigue
   - ☐ Breathlessness at rest/light work/exercise
   - ☐ Worsening of chronic illnesses
   - ☐ Any psychological disorders including insomnia, anxiety, panic attacks,
   - ☐ Chronic/continuous pain
   - ☐ Weight loss
   - ☐ None of the above

4. Do you consume/were you consuming tobacco in any form including smoking. ☐ Yes ☐ No

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). Add this declaration here for

Applicant Signature

Date: _____

Place: _____

IndiaFirst Life Insurance Company Ltd.,
12th and 13th Floor, North [C] Wing, Tower 4, Nesco IT Park, Nesco Center, Western Express Highway, Goregaon (East), Mumbai – 400063,
IRDAI Regd. No. 143 | CIN: U66010MH2008PLC183679.

Tel: +91 22 6165 8700 **Fax:** +91 22 6857 0600 **Toll Free:** 1800-209-8700
E-mail: customer.first@indiafirstlife.com **Website:** www.indiafirstlife.com

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Part C

POST- COVID FITNESS QUESTIONNAIRE (TO BE FILLED BY LIFE ASSURED TREATING PHYSICIAN/PERSONAL PHYSICIAN)

- Did life assured visit you or any other doctor post covid-19 illness for any health reasons? If so, please provide details including presenting symptoms, investigations done, diagnosis, treatment given etc ☐ Yes ☐ No
- Does life assured suffer from chronic illnesses? Have they worsened post covid-19 illness? ☐ Yes ☐ No
- Please confirm whether life assured suffers from any illnesses/issues, including but not limited to:
  - ☐ Chronic fatigue
  - ☐ Breathlessness at rest/light work/exercise
  - ☐ Worsening of chronic illnesses
  - ☐ Any psychological disorders including insomnia, anxiety, panic attacks etc
  - ☐ Any cognitive impairment
  - ☐ Chronic/continuous pain
  - ☐ Poor endurance
  - ☐ Any myopathy/neuropathy
  - ☐ Any pulmonary manifestations of covid-19
  - ☐ Any indication/sequelae of hyper-coagulation of blood
  - ☐ Impaired renal function
  - ☐ Any indication of myocardial injury
  - ☐ Any other issue not mentioned above
  - ☐ None of the above
- If you treated life assured for covid-19, Please comment on severity of illness, treatment given & current status of life assured ☐ Yes ☐ No

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.

Physician Signature

Date:

Place:

(Please affix Physician Seal here)