FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

COVID-19 QUESTIONNAIRE

Proposal No: _____ Name of the Life Assured: _____

1.	Did you travel or plan to travel to a COVID-19 affected country in the past 20 days or in the next 90 days? If yes, please share details about travel locations and exact durations of stay(s) along with NRI questionnaire	☐ Yes ☐ No
2.	Within the last 14 days, did you have close contact with a confirmed or suspected COVID-19 infected person?	☐ Yes ☐ No
3.	Are/were you quarantined or have you been advised to self-isolate at home (by authorities/officials, a health care provider, medical staff or a medical advisor or by any other institution) or have you decided on your own to self-isolate yourself? If yes, please provide the reason for quarantine or self-isolation	☐ Yes ☐ No
4.	Have you been diagnosed (based on a positive COVID-19 test result or based on your symptoms and your personal risk parameters) to have a proven or likely COVID-19 infection?	☐ Yes ☐ No
5.	Did you ever have a COVID-19 test?	☐ Yes ☐ No
	• If yes, was it negative (i.e. COVID-19 virus was not detected) or was it positive (i.e. you were found to have a COVID-19 infection)? Please share details of all testing dates and results.	
	• If no, is a COVID-19 test planned/recommended for you?	☐ Yes ☐ No
6.	Do you currently suffer or did you suffer during the last 14 days from any of the following symptoms:	
	• Sore throat for 3-4 consecutive days	☐ Yes ☐ No
	• Runny nose for 3-4 consecutive days	☐ Yes ☐ No
	• Aches and pains for 2-3 consecutive days	☐ Yes ☐ No
	• Tiredness for 2-3 consecutive days	☐ Yes ☐ No
	• Fever of 38°C or above for 3-4 consecutive days	☐ Yes ☐ No
	• Cough for 3-4 consecutive days	☐ Yes ☐ No
	• Shortness of breath	☐ Yes ☐ No
	• Difficulty breathing	☐ Yes ☐ No
	• Persistent pressure or pain in your chest	☐ Yes ☐ No
	• Bluish lips or face	☐ Yes ☐ No
	• Confusion or inability to arouse	☐ Yes ☐ No
7.	Have you been admitted to a hospital (or to any other kind of medical or public health institution/unit) while you have/had a COVID-19 infection or whilst you are/were suspected to have a possible COVID-19 infection? If yes, please share details of exact admission period and location(s).	☐ Yes ☐ No
8.	Do you work in an occupation, where you have a higher risk to get in close contact with COVID-19 patients or with coronavirus contaminated material? If yes, please share details about your exact occupational duties.	☐ Yes ☐ No

I hereby declare, that the above answers and statements are true and complete, and also agree that this questionnaire, together with the proposal shall form a part of the contract between the company and myself.

Place: _____

Date: _____

X _____

Signature of the Life Assured / Proposer
(In case of LA is Minor)

Vernacular declaration: I have explained the contents of this form and have read out the responses to the Life Insured in his/her local language. He/she has confirmed that the contents are fully understood by him/her.

Name of the Declarant: _____

Address of the Declarant: _____

Place: _____

Date: _____

_____

Signature of the Declarant

X _____

Signature of the Life Assured / Proposer
(In case of LA is Minor)