FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

COVID-19 QUESTIONNAIRE

TO BE FILLED BY THE APPLICANT

Name of the Life Insured

Proposal Number

PLEASE ANSWER EACH QUESTION AND PROVIDE PARTICULARS WHEREVER REQUIRED

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? ☐ Yes ☐ No
   If yes, please provide the reason for quarantine or self-isolation
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 negativev (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 22-3 consecutive days ☐ Yes ☐ No
   - Fever of 38^0C 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 possibile COVID-19 infection? ☐ Yes ☐ No
   If yes, please share details of exact admission period ad location(s).
8. Do you work in an occupation, where you have a higher risk to get in close contact with COVID-19 patients or with corona virus contaminated material? ☐ Yes ☐ No
   If yes, please share details about your exact occupational duties.

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: _____

_____

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: _____

_____

_____

_____

Signature of the Declarant

Place: _____ Date: _____

_____

Signature of the Life Assured / Proposer

(In case of LA is Minor)