Annexure B-CVD_03.20

SHRIRAM Life Insurance
YOUR PARTNER FOR PROSPERITY
associated with Sanlam group

COVID-19 (Coronavirus) Exposure Questionnaire for Health Care Professionals

(To be filled by Life Assured only)

Name of the Life insured: _____ Proposal/Policy No: _____

Please provide the following information with as much details as possible:

	Yes	No
1. Occupation : _____		
2. Medical Speciality (if applicable):_____		
3. Exact nature of duties (including procedural or non-procedural duties):_____		
4. Name and address of health care facility or facilities in which you work:_____		
5. Name of the health authority under which you are registered:_____		
6. Does your health care facility have sufficient personal protective equipment (PPE)to provide to its work force	☐	☐
7. Have you been or do your work duties involve 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 including nature of work for patients with novel coronavirus (SARS-CoV-2/COVID-19).	☐	☐
8. Have you ever been on voluntary leave, or placed on compulsory leave of absence/sick leave, due to a possible exposure to novel coronavirus (SARS-CoV-2/COVID-19)? If yes, please provide relevant dates and details (1 Health care Workers shall mean all registered health care professionals (doctors, nurses, allied health professionals including physiotherapists, pharmacists, phlebotomists etc.) involved in direct patient care)	☐	☐
9. Have you ever tested positive for, or are you awaiting the rest results of novel coronavirus (SARS-CoV-2/COVID-19)? If yes, please provide relevant dates and details, including the results of any test(s) where known.	☐	☐
10. Have you experienced any of the following symptoms within the last 14 days? Any fever, cough, shortness of breath, malaise (flu-like tiredness, rhinorrhoea (mucous 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.	☐	☐
11. Are you currently in good health and actively at work?	☐	☐

Please provide the details below if any of above question is answered as "Yes"

12	**Travel Declaration**			
12.a	Please provide your travel patterns over the last 5 months (please provide copy of all pages of passport of life assured showing entry and exit of below travel dates):			
	COUNTRY	**CITY**	**DATE ARRIVED**	**DATE DEPARTED**
12.b	Please detail your intended future travel plans for the next 6 months:			
	COUNTRY	**CITY**	**Proposed date of Travel**	**Planned duration of stay**
12.c	If you have been screened at the airport, please provide copy of report			

I confirm that the answers I have given are true to the best of my knowledge 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) contract.

Date: _____

Place: _____

_____
Signature of Life Assured