Annexure-I

LIFE INSURANCE CORPORATION OF INDIA

Novel Coronavirus(Covid-19)Questionnaire (Revised version-5)

(To be completed by life to be assured / Proposer in case of minor life)

Name of the life to be assured:

Proposal No:

I	Is life to be assured currently residing outside India, If Yes please give a. Name of Country b. Date of Travel c. Since when	
II	Has life to be assured any plan to visit any foreign country till 31.12.2020 . If yes , a. Name of the country/ Countries b. Date of journey(to and fro) c. Duration of stay	
III	Have you travelled abroad in the past 14 days? If yes please give the following a. Name of the country/ Countries b. Date of Return to India c. Duration of stay	
IV	Is life to be assured, or has life to be assured been in close contact with anyone who has been quarantined or who has been diagnosed with Covid-19 within last 14 days ? If yes , please give details.	
V	Has life to be assured experienced any of the symptoms (for more than 5 days) such as 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 diarrhoea, Chills, Repeated shaking with chills, Muscle pain, Headache, Loss of taste or smell within last 14 days. If Yes , provide all investigation and treatment details.	
VI	a. Are you a Health Care Worker b. If yes please provide details of service / nature of duties . c. Whether enrolled as Corona warrior or working in Hospital/ clinic with novel coronavirus (SARS-CoV-2/COVID-19) ward/unit or treating/ in contact with Covid-19 infected individuals. If yes, provide details d. Whether there is any symptoms as mentioned in point V. e. Whether Tested for Covid -19 , If yes Report of the same Health Care worker (HCW): IncludesDoctors, General Practitioners, Hospital Doctors, Surgeons, Therapists, Nurses, Pathologist, paramedics, Pharmacist, Ward helpers, Individuals working in Hospitals/ Clinics	
VII	Has life to be assured ever been diagnosed with Covid-19 , If yes a. Date of diagnosis b. Name of hospital where life to be assured was admitted and treated for Covid-19. c. Date of discharge after fully cured. Please submit discharge summary, all investigation reports including all Covid-19 reports .	
VIII	Any other Information related to above (additional information can be given on a separate sheet)	

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 proposal.I agree that this form will constitute part of my proposal for insurance(s) and that failure to disclose any material fact known to me may invalidate my insurance(s).

Date&Place:

Signature of life to be assured/ Proposer