AIA SINGAPORE

COVID-19 (CORONAVIRUS) EXPOSURE QUESTIONNAIRE

Particulars of Insured and Policy Owner

Name of Insured

NRIC/Passport/FIN No.

Name of Policy Owner

NRIC/Passport/FIN No.

Policy Numbers

Questions

Please answer the following questions with as much detail as possible:

1. Are you, or have you been in close contact with anyone who has been quarantined or who has been diagnosed with novel coronavirus (SARS-CoV-2/COVID-19)?

   ☐ Yes ☐ No

   If **Yes**, please provide details. Eg relationship and date of last contact (DD/MMM/YY)

2. Have you ever been quarantined due to a possible exposure to novel coronavirus (SARS-CoV-2/COVID-19)?

   ☐ Yes ☐ No

   If **Yes**, please provide detail.

   Last date of quarantine (DD/MMM/YY)

   Country

   Reason (E.g. travel history, local cluster, unlink, etc.)

3. Have you been advised to be tested to rule in, or rule out, a diagnosis of novel coronavirus (SARS-CoV-2/COVID-19)? Or, are you awaiting the result of a test which has already been submitted for the novel coronavirus (SARS-CoV-2/COVID-19)?

   ☐ Yes ☐ No ☐ Pending result

4. Have you ever tested positive for the novel coronavirus (SARS-CoV-2/COVID-19)?

   ☐ Yes ☐ No

   If **Yes**, provide the date of positive diagnosis and complete **Section A** below. If **No**, please proceed to **Question 5.**

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Section A (Please complete the following only if you had tested positive for Covid-19).

4a. Why did you receive a COVID-19 test? (select one).

- Had symptoms/was ill (Please describe your symptoms) ☐
- Had exposure to someone with known COVID-19 infection but had no symptoms. ☐
- As part of a general screening/testing program, but had no symptoms ☐
- Other (please provide the details) ☐

4b. Did you require admission to hospital?

☐ Yes ☐ No

If **Yes**, please provide date of admission and discharge. Please submit copy of discharge report, if available.

4c. Did you require self-isolation only?

☐ Yes ☐ No

If **Yes**, please provide details.

Start date of isolation (DD/MMM/YY)	
End date of isolation (DD/MMM/YY)	
Place of self- isolation	
Have you experienced any **symptoms** including fever during self-isolation?	
Did you require **treatment/ medication**?	
Result of **repeat test** after completed self-isolation (if any). Please attach copy of result and discharge memo.	
4d. Date of full recovery with complete resolution of symptoms and no complication. (DD/MMM/YY)	

If symptom persists and/or complication developed, please provide details.

4e. Did you consult any doctor upon your recovery from COVID-19?

☐ Yes ☐ No

If **Yes**, please provide the date of consultation and outcome. Please attach copy of investigation report(s).

4f. Do you have any pending or recommended follow-up and tests related to COVID-19?

☐ Yes ☐ No

If **Yes**, please provide the type of test required, date of test. Please attach copy of result.

5. Have you experienced any of the following symptoms within the last 14 days?

☐ Yes ☐ No

- 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 diarrhea ☐

If **Yes**, to any of these symptoms, please indicate which and provide full information.

6. Have you travelled abroad in the past 14 days or do you plan to travel for the next 30 days?

☐ Yes ☐ No

If **Yes**, please provide the details where applicable.

a) Please provide your travel patterns over the past 14 days:

COUNTRY	CITY	DATE ARRIVED	DATE DEPARTED

b) Please detail your intended future travel plans for the next 30 days:

COUNTRY	CITY	DATE ARRIVAL	INTENDED DURATION

7. Are you currently in good health?

☐ Yes ☐ No

If **No**, please provide details of current health conditions (E.g. symptoms, diagnosis, whether currently on treatment and/or follow up, etc.)

8. Have you been fully vaccinated?

Fully vaccinated - more than 14 days or 28 days (depending on type of vaccine) after completing vaccination regimen recognised in the WHO EUL (Emergency Use Listing) account (both doses of the vaccine or one dose for recovered individuals)

☐ Yes ☐ No

Declaration and Authorisation

I hereby declare and agree that the above particulars and answer are complete and true, and this questionnaire will form part of the contract for the desired insurance on my life. I also authorise AIA Singapore Private Limited to obtain, if necessary, confidential reports from any doctor/clinic/hospital that I have referred above.

Signature of Insured	Signature of Policy Owner ** Applicable if Insured is under age 16*
Date	Date

FSC/IR's Name	FSC/IR's Code	FSC/IR Unit Name	Mobile No.