COVID-19 questionnaire

Full name of life to be insured | Date of Birth

Application/Policy/Fund No: | Member No: (if applicable)

Fund Name (if applicable)

1. Are you currently being investigated or monitored for COVID-19? ☐ Yes ☐ No

If 'Yes', please answer the following questions:

If 'No', ***go to question 2***.

(a) Please select which of the following symptoms you are currently experiencing.

- ☐ Fever
- ☐ Flu-like symptoms or fatigue
- ☐ Cough or sore throat
- ☐ Loss of smell or taste
- ☐ Shortness of breath
- ☐ Muscle or joint pain
- ☐ I'm not experiencing any symptoms

(b) Have you had a COVID-19 test? ☐ Yes ☐ No

If 'Yes', what is the result of your most recent COVID-19 test?

- ☐ I have COVID-19 ***(continue to question 2)***
- ☐ I do not have COVID-19 ***(continue to question 1c)***
- ☐ I am still awaiting the result of the test ***(continue to question 1c)***

If 'No', are you scheduled or intend to have a COVID-19 test? ☐ Yes ☐ No

Please provide details (i.e. date of appointment etc.)

(c) Have you been advised or currently in quarantine or in self-isolation for COVID-19? ☐ Yes ☐ No

If 'Yes', please provide details (such as duration required, date of completing self-isolation/quarantine, reason etc.)

2. Have you tested positive for or been diagnosed with COVID-19? ☐ Yes ☐ No

If 'Yes', please answer the following questions:

(a) When was your positive test/diagnosis for COVID-19?

(b) Did you require hospital admission as a result of COVID-19? ☐ Yes ☐ No

If 'Yes', please answer the following:

i) Did you require admittance to Intensive Care Unit? ☐ Yes ☐ No

ii) Did you require breathing assistance from a ventilator? ☐ Yes ☐ No

iii) Date of hospital discharge

iv) Details of treating doctor

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(c) Have you fully recovered with no ongoing symptoms (examples listed below), no complications, no treatment required, no further follow ups with your doctor and fully returned to work at full capacity? ☐ Yes ☐ No

Example of symptoms include (but not limited to) cough, fatigue, tiredness, shortness of breath, difficulty in breathing, chest pain, memory, concentration or sleep problems, fever, difficulty concentrating or brain fog, joint/muscle aches/pains, headache, loss of smell or taste, dizziness, worsened symptoms after physical or mental activities, depression or anxiety).

If 'Yes', please answer the following:

i) Date of recovery (or date of last symptoms)

ii) Duration of symptoms (days/weeks/months)

If 'No', please provide the following details:

i) Type of symptoms (if any)

ii) Type of complications (if any)

iii) Type of treatment (if any)

iv) Any impact on your ability to work (any time off work, any reduced hours or modification in duties)

v) Others:

(d) Have you been advised or currently in quarantine or in self-isolation for COVID-19? ☐ Yes ☐ No

If 'Yes', please provide details (such as duration and date of completing self-isolation/quarantine, reason etc.)

Declaration

I declare that the answers I have provided to the questions in this form are honest, true and correct to the best of my knowledge. I understand that this document will form part of my application for insurance and the answers provided will be used by AIA Australia to determine whether to offer insurance and if so on what terms.

I understand my obligations under the Duty to take reasonable care not to make a misrepresentation and am aware of the consequences of not meeting this duty.

Signature of life to be insured ✗

Date