Annexure-I

LIFE INSURANCE CORPORATION OF INDIA

Novel Coronavirus(Covid-19)Questionnaire (Revised version-8)
(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 under quarantine in the last 14 days in view of living / close contact with anyone diagnosed with Covid-19 or been serving notice of quarantine by health / government/ airport authority. If yes, please provide more details like location, date of infection of last infected person (in case of co-habitation with more than 1 person), quarantine period.	
II	Has the life to be assured a. ever been advised to be tested to rule in or rule out, a diagnosis of novel coronavirus in last 14 days. If Yes, result of the test b. experienced any of the symptoms 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 the last 14 days. If Yes , provide all investigation and treatment details.	
III	Has life to be assured ever been diagnosed with Covid-19 , If yes a. Date of diagnosis b. Whether home quarantined / in Covid Care Centre (CCC) / Hospitalized c. If hospitalized, name of the hospital where life to be assured was admitted and treated for Covid-19. d. Date of discharge after fully cured. Please submit discharge summary, all investigation reports including all Covid-19 test results.	
IV	Is life to be assured an NRI/FNIO/ OCI, If Yes please give a. Name of the country of residence. b. Are you currently residing in India, if yes since when c. Date of arrival in India d. Date of return to country of Residence	
V	Has life to be assured been vaccinated for novel coronavirus (SARS-CoV-2/COVID-19). If yes a. Date of first dose b. Date of second dose c. Name of vaccine d. Have you experienced any adverse reaction post vaccination. If yes, please share details including treatment taken for adverse reaction (and how many days after vaccination) Copy of vaccination certificate (or copy of any official documentation confirming complete vaccination issued by the relevant health authority) Please note self-declarations are not acceptable.	

Declaration: I confirm that the answers given above by me 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