COVID–19
Supplementary Questionnaire

Given Name(s)

Family Name

Quotation Reference Number

1. Have you been vaccinated against COVID-19? ☐ Yes ☐ No Date DDMMYYYY

IF YES, PLEASE PROVIDE US WITH A COPY OF YOUR VACCINATION CERTIFICATE.

2. Have you tested positive for COVID-19?
*If **Yes**, please provide the most recent date you tested positive.* ☐ Yes ☐ No Date DDMMYYYY

IF YOU HAVE TESTED POSITIVE, PLEASE ANSWER THE QUESTIONS 3 TO 6 - IF YOU HAVE NOT TESTED POSITIVE, LEAVE THESE BLANK AND SIGN THE FORM.

3. Please indicate which of the following best represents your symptoms.

☐ **Asymptomatic, mild to moderate symptoms**
Asymptomatic - *no symptoms experienced at all; diagnosis confirmed only by testing.*
Mild to moderate symptoms - *fever, sore throat, persistent cough, shortness of breath, fatigue, headache, muscle aches, nasal congestion, nausea, loss of sense of smell and/or taste.*

☐ **Severe symptoms**
Severe symptoms - *diagnosis of pneumonia but no ventilator has been used in treatment.*

☐ **Critical symptoms**
Critical symptoms - *severe pneumonia, acute respiratory distress syndrome (ARDS), admission to intensive care with mechanical ventilation support necessary.*
Other critical symptoms may include sepsis, kidney failure, multiple organ failure, myocarditis, thrombosis, pulmonary embolism, stroke, heart attack.

4. Were you admitted to hospital? ☐ Yes ☐ No Date admitted DDMMYYYY

5. Did you require support from a ventilator? ☐ Yes ☐ No Date discharged DDMMYYYY

IF YOU ANSWERED YES TO QUESTIONS 4 OR 5, PLEASE PROVIDE AS MUCH RELATED DETAIL IN THE SPACE BELOW.

6a. Have you fully recovered? ☐ Yes ☐ No
No residual symptoms, able to return to work or resume normal activities.

6b. If **Yes**, what date did you last experience symptoms? Date DDMMYYYY

6c. If **No**, please provide as much detail as possible about your current symptoms.

Declaration by Life Insured

I declare that the above information is true, complete and precise, and I agree that, together with my Application, it shall form the basis of my Policy.
I undertake that I will notify Unisure Limited as soon as possible if any of the answers provided above change before the commencement of my Policy.

Signature of Life Insured

Date DDMMYYYY

FAILURE TO PROVIDE ACCURATE INFORMATION AND COMPLETE ANSWERS MAY RESULT IN NON-PAYMENT OF A CLAIM