Viral Epidemic

* Q U E S T *

QUESTIONNAIRE

PARTICULARS OF LIFE ASSURED

Name
Identity Card / Passport No
Contract No.

QUESTIONS

Important: You only need to complete this questionnaire if you had been diagnosed with COVID-19 infection or had a positive antibody test indicating past infection.

1. Do you currently have any
   - symptom(s) (such as shortness of breath, chronic fatigue, restriction in physical ability etc), or
   - complication associated with COVID-19 infection (such as abnormal blood test, scan, chest x-ray or any other medical condition), or
   - limitation(s) in performing daily activities as compared to before the infection, e.g. intensity of physical/ routine activities affected and/ or unable to return to work/ school

   ☐ No.

   ☐ Yes. Please provide details, including symptoms or complications, treatment and follow-up required.

2. Are you required to be on follow-up currently?

   ☐ No. Date of full discharge from all reviews: _____ (mm/yyyy)

   ☐ Yes, please provide details below.

   Date of most recent follow-up: _____ (mm/yyyy)

   Type of treatment received

3. Please provide details of treatment for Covid-19 infection.

   ☐ Nil (applicable only for positive antibody indicating past infection)

   ☐ Community care facility

   ☐ Admitted to hospital, general ward only. Period of stay(s): _____ days.

   ☐ Admitted to hospital and required to be put on a ventilator or stay in Intensive Care Unit (ICU), Critical Care Unit (CCU) or High-dependency Unit (HDU). Please provide details below.

   Length of stay in ICU/ CCU/ HDU wards: _____ days.

   Date of discharge: _____ (mm/yyyy)

4. Please provide details of your attending doctor(s) and hospital(s).

UWQPE.04

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DECLARATION

I/We agree to inform Singapore Life Ltd. if there is any change in my/our health status between the date of this Declaration and the date full insurance coverage is provided by Singapore Life Ltd. to me/us. I/We understand that the terms of accepting me/us as a risk for insurance coverage may vary according to such information received.

I/We agree that the above information shall form the basis of my/our application for insurance. I/We declare that the information given is true and complete and I/we have not withheld any material information that may influence the assessment of my/our application.

Signature of Life Assured

Name

Date (DD/MM/YY) ☐☐ / ☐☐ / ☐☐

Signature of Assured

Name

Date (DD/MM/YY) ☐☐ / ☐☐ / ☐☐

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