Policy Number

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COVID-19 QUESTIONNAIRE - Applicant
(To form part of the policy contract)

Name of Applicant: _____

1. When were you diagnosed of COVID-19? _____

2. What was the severity of COVID-19 infection?

- ◯ **Asymptomatic** (tested positive only but no presented symptoms)
- ◯ **Mild** (No history of hospitalization or pneumonia due to COVID-19; or admitted to hospital for isolation or observation only)
- ◯ **Moderate** (with history of pneumonia, hospitalization, or in-patient treatment (excluding ICU due to COVID-19)
- ◯ **Severe** (with history of hospitalization or in-patient treatment (including ICU due to COVID-19 with or without use of ventilator)

3. Were you prescribed any medication for this condition? ◯ YES, please provide details ◯ NO

DATE PRESCRIBED	NAME OF MEDICATION	DOSAGE	DATE MEDICATION STOPPED & REASON/S	
/ /			/ /	
/ /			/ /	
/ /			/ /	
/ /			/ /	

4. Were there tests done in relation to COVID-19? ◯ YES, please provide details ◯ NO

DATE PERFORMED	TYPE OF TEST	RESULT
/ /	RT-PCR	
/ /	ECG	
/ /	CXR	
/ /	BLOOD TEST	
/ /	OTHERS	

5. Have you ever had or currently have any of the following medical conditions?

☑	MEDICAL CONDITIONS		
☐	Asthma	☐	COPD
☐	Auto-immune Diseases	☐	Diabetes
☐	Cardiovascular Disease	☐	Hypertension / High Blood Pressure
☐	Cancer	☐	Hypercholesterolemia/ Dyslipidemia
☐	Chronic Kidney Disease	☐	Obesity
☐	Chronic use of high-dose steroids/ Immunosuppressants	☐	Others (please specify)

6. Have you been admitted to a hospital/facility due to COVID-19? ◯ YES, please provide details ◯ NO

DATE ADMITTED	DATE DISCHARGED	NAME OF HOSPITAL/FACILITY	REASON FOR CONFINEMENT
/ /	/ /		
/ /	/ /		

7. Have you had pneumonia during COVID-19 infection? ◯ YES, ~~please provide details~~ ◯ NO

8. Were you vaccinated for COVID-19? ◯ YES, please provide details ◯ NO

DATE OF VACCINATION	VACCINE BRAND	TYPE OF DOSE (1ST DOSE, 2ND DOSE, BOOSTER)
/ /		
/ /		
/ /		
/ /		

9. Has there been any recurrence of COVID-19 infection? ◯ YES, please provide details ◯ NO

Date of last infection _____ Date of last symptoms _____

10. Are you currently under observation or medical supervision for COVID-19 complications or long COVID? ◯ YES, please provide details ◯ NO

_____

Name of Attending Physician:	Specialization:
Contact Number:	Email Address:
Clinic Address	

DECLARATION

I confirm that the answers I have given are, to the best of my knowledge, true and correct and that I have not withheld any material information that may influence the assessment or acceptance of this application.

I understand that the personal information collected or held by AXA Philippines may be used, stored, transferred (whether within or outside the Philippines) to such persons as AXA Philippines may consider necessary, including any of its affiliates or related companies, or any individuals/organizations/corporations/entities associated with AXA Philippines to process and deal with my application/policy to which this is appended to.

I agree that this form will constitute part of my application for insurance and that failure to disclose any material fact known to me may invalidate my insurance. Furthermore, I understand that declaration of any untruthful statement may also be a ground to invalidate my insurance.

_____ _____

Name and Signature Date of Signing

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