

## COVID-19: Recovery questionnaire

Policy number

Member number\*

Group number\* (\*Fill in for FundsAtWork)

### 1: Personal details

Name of insured life

Permanent identity/passport number

Date of birth

Cellphone number

Email address

Permanent identity number  Yes  No

Passport expiry date

Alternative number

### 2: General questions

1. On which date were you diagnosed with SARS-CoV-2/COVID-19?

2. Which symptoms did you have when you were diagnosed?

a. Any fever	Yes <input type="text"/>	No <input type="text"/>
b. Cough	Yes <input type="text"/>	No <input type="text"/>
c. Shortness of breath	Yes <input type="text"/>	No <input type="text"/>
d. Loss of taste or smell	Yes <input type="text"/>	No <input type="text"/>
e. Sore throat	Yes <input type="text"/>	No <input type="text"/>
f. Muscle ache	Yes <input type="text"/>	No <input type="text"/>
g. Tiredness/fatigue	Yes <input type="text"/>	No <input type="text"/>
h. Gastro-intestinal symptoms such as nausea, vomiting and/or diarrhea	Yes <input type="text"/>	No <input type="text"/>

If yes, provide full information

3. What was the last date you experienced any symptoms?

4. Were you admitted to hospital due to COVID?

Yes <input type="text"/>	No <input type="text"/>
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a. On which date were you admitted?

b. Were you admitted in ICU?  Yes  No

c. Were you in a general ward?  Yes  No

d. On which date were you discharged?

5. Treatment:

a. Were you on a ventilator?	Yes <input type="text"/>	No <input type="text"/>
b. Were you on high flow oxygen for a continuous period of more than 10 days?	Yes <input type="text"/>	No <input type="text"/>
c. Normal oral meds?	Yes <input type="text"/>	No <input type="text"/>
d. Other?	Yes <input type="text"/>	No <input type="text"/>

If other, provide information

Other

a. You did not have any symptoms?	<input type="text"/>
b. There were no beds available and you were forced to isolate at home?	<input type="text"/>
c. Personal preference treatment at home?	<input type="text"/>
d. Symptomatic but not severe enough to require hospital?	<input type="text"/>

## 2: General questions (continued)

6. How long were you booked off from work?

a. I am currently not back at work due to COVID	
b. ≥ 20 days	
c. 15 – 19 days	
d. 10 – 14 days	
e. 5 – 9 days	
f. Never booked off/working from home	

7. When did you return to work or resume normal activities?

a. Date

D	D	M	M	Y	Y	Y	Y
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b. Do you have any difficulty in doing a normal days work?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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c. Are there any physical limitations in doing a normal days work?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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If yes, provide more details

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8. Do you currently have any ongoing symptoms or complications as a result of Covid-19? (Examples mentioned in the list below.)

a. Yes, I still have symptoms/complications (select from list below)	<input type="checkbox"/>	b. No, I am fully recovered	<input type="checkbox"/>
Still have a lingering disease	<input type="checkbox"/>		
Organ damage	<input type="checkbox"/>		
Coagulation/clotting disorders	<input type="checkbox"/>		
Presence of comorbidities like diabetes, hypertension	<input type="checkbox"/>		
Fatigue/tiredness/confusion/cognitive disorder	<input type="checkbox"/>		
Breathlessness/shortness of breath or difficulty breathing	<input type="checkbox"/>		
Other	<input type="checkbox"/>		

If other, provide more details

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## 3: Declaration by insured life

I declare that all the statements that I have made and details that I have supplied in this form (whether in my own handwriting or not), are complete and true. I also understand and agree that the information that I have supplied, together with the application for life insurance and any other relevant documents, will form the basis of any insurance contract that may come into existence as a result of such application.

Signed at

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Signature of insured life

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Date

D	D	M	M	Y	Y	Y	Y
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