Covid-19 Exposure Questionnaire

Best Meridian International Insurance Company SPC

BMII COMPANIES

Proposed insured's full name

Please answer the following questions with as much detail as possible:

1. Are you, or have you been in close contact with anyone who has been quarantined or who has been diagnosed with novel coronavirus (SARS-CoV-2/COVID-19)? If yes, please provide details.

    Yes ☐   No ☐

    _____

    _____

2. Have you ever been quarantined due to a possible exposure to novel coronavirus (SARS-CoV-2/COVID-19)? If yes, please provide dates and locations.

    Yes ☐   No ☐

    _____

    _____

3. Have you been advised to be tested to rule in, or rule out, a diagnosis of novel coronavirus (SARS-CoV-2/COVID-19)? Or, are you awaiting the result of a test which has already been submitted for the novel coronavirus (SARS-CoV-2/COVID-19)?

    Yes ☐   No ☐

4. Have you ever tested positive for the novel coronavirus (SARS-CoV-2/COVID-19)? If yes, provide the date of positive diagnosis.

    Yes ☐   No ☐

    _____

    _____

5. Have you experienced any of the following symptoms within the last 14 days?

    - 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 diarrhea

    If yes, to any of these, please indicate which and provide full information.

6. Travel Declaration

    a. Please provide your travel patterns over the past 14 days:

COUNTRY	CITY	DATE ARRIVED	DATE DEPARTED

    b. Please detail your intended future travel plans for the next 30 days:

COUNTRY	CITY	DATE ARRIVAL	INTENDED DURATION

7. Are you currently in good health?
    Yes   No

Declaration

I confirm that all answers presented in this questionnaire are complete and true, and that I have not withheld any material information that may influence the assessment or acceptance of this application.

I agree that this form will constitute part of my application for insurance(s) and that failure to disclose any material fact known to me may invalidate my insurance coverage(s).

Signed on _____/_____/_____
        Month / Day / Year

_____
        Proposed insured's signature