Assurity®
Assurity® Life Insurance Company
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COVID-19 Questionnaire

PLEASE USE A SEPARATE FORM FOR EACH PROPOSED INSURED

Proposed Insured _____
First *Middle* *Last*

Proposed Insured's Social Security No. _____ Proposed Insured's Date of Birth _____

Completed By _____ Relationship to Proposed Insured _____
(If completed by someone other than Proposed Insured)

PLEASE ANSWER THE FOLLOWING QUESTIONS

1. In the past **12 months**, has the Proposed Insured consulted with, been diagnosed, treated, hospitalized or prescribed medication by a medical professional for COVID-19? ☐ Yes ☐ No

   If YES, provide the date of diagnosis or treatment, any resulting medical complications of COVID-19 and the physician and/or medical facility consulted.

Date of Diagnosis or Treatment *(MM/DD/YYYY)*	Resulting Complications? If Yes, provide details below.	Physician/Medical Facility Consulted
/ /	☐ Yes ☐ No	
Details:		

2. In the past **3 months**, has the Proposed Insured been tested by a member of the medical profession for COVID-19 with a positive result, or been advised by a member of the medical profession to be tested for COVID-19? ☐ Yes ☐ No

   If YES, provide date of test, result of test and physician and/or medical facility consulted.

Date of Test *(MM/DD/YYYY)*	Test Result	Physician/Medical Facility Consulted
/ /	☐ Positive ☐ Negative ☐ Unknown	

3. In the past **3 months**, has the Proposed Insured traveled outside of the United States? ☐ Yes ☐ No

   If YES, provide detail of all countries and cities visited and corresponding dates.

Date of Travel *(MM/DD/YYYY)*	Country Visited	Cities Visited
/ / through / /		

AGREEMENT

I have read the above questions and declare the answers are complete and true to the best of my knowledge and belief. I understand this questionnaire will be used as a supplement to my application for insurance and agree it shall form a part of the policy if attached thereto.

_____ / /
Signature of Proposed Insured or Source *Date of Signature (MM/DD/YYYY)*