AXA COVID-19 Recovery Questionnaire

Name of the Proposed Insured/Proposed Owner:	
Policy/Application Number:	

1. On what date were you diagnosed with SARS-CoV-2/COVID-19? *(DDMMYY)*

2. What type of test was used to make the diagnosis? (Select Tick ✓ one)

   a) RT-PCR test (usually performed with a nasal and throat swab) ☐

   b) RTK-Antigen test (usually performed with a nasal and throat swab) ☐

   c) Antibody test (usually performed with a finger prick or blood test) ☐

   d) I do not know ☐

3. Did you receive a printed or electronic report with your test result? If yes, please return a copy with this questionnaire.
   Yes ☐ No ☐

4. Why did you receive a COVID-19 test? (Select Tick ✓ one)
   a) Had symptoms/was ill ☐

   b) Had exposure to someone with known COVID-19 infection, but had no symptoms ☐

   c) As part of a general screening/testing program, but had no symptoms ☐

   d) Other (please provide details) ☐

AXA AFFIN Life Insurance Berhad 200601003992 (723739-W)
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Customer Service: 1300 88 1616 Medical Card: 1300 80 0200 customer.care@axa-life.com.my www.axa.com.my

5. At any time did you require admission to hospital for observation, quarantine, or treatment of COVID-19?

   Yes ☐ No ☐

   If YES, please continue:

   a) Was admission for observation or quarantine purposes only and at no time did you have symptoms and/or require treatment?
      Yes ☐ No ☐

   b) Date of admission? ☐ Date of discharge? ☐

   c) Did you require treatment in the intensive care unit (ICU)?
      Yes ☐ No ☐

   d) Did you require a machine to help you breathe?
      Yes ☐ No ☐

   e) What complications did you experience such as lung (respiratory), kidney, liver, or heart problems related to the COVID-19 infection? (Please provide details).

6. What symptoms do you have at this time? (Select all that apply ✓)

   a) Fatigue or loss of energy ☐
   b) Concentration difficulties ☐
   c) Fever ☐
   d) Cough ☐
   e) Body ache ☐
   f) Headaches ☐
   g) Shortness of breath ☐
   h) Depressed mood ☐
   i) No symptoms ☐

7. Date on which you experienced complete recovery:

8. Do you have any pending or recommended follow-up appointments or tests related to your COVID-19 diagnosis?

Yes ☐ No ☐

If YES, please list dates and test:

Date (DDMMYYYY)	Test

9. If employed, have you been certified to return to work on an unrestricted and full-capacity basis?

Yes ☐ No ☐

If NO, please provide details:

Signed at: _____ (*e.g. Kuala Lumpur)*

on this day: _____ (*Date*) of _____ (*Month*) , _____ (*Year*)

Witness's Signature :

Signature of Proposed Insured :

Signature of Policy Owner :

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