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)*