BROOKFIELD PARTNERS

COVID-19 (Coronavirus) Questionnaire

UNDERWRITING QUESTIONNAIRE

AGENT & CASE INFORMATION

AGENT NAME | PHONE | E-MAIL

PROPOSED INSURED

CLIENT NAME | DATE OF BIRTH | STATE

HEIGHT | WEIGHT | FACE AMOUNT

Sex: ☐ Male ☐ Female

Tobacco / Nicotine Use: ☐ Yes ☐ No

COVERAGE REQUESTED

Type of Insurance: ☐ Universal Life ☐ Whole Life ☐ Survivorship

☐ Term — number of years:

QUESTIONNAIRE

1. Has the proposed insured ever been diagnosed with COVID-19 and/or had a positive test result? ☐ Yes ☐ No

2. What treatment was given?

3. What symptoms did the proposed insured have?

Fever: ☐ Yes ☐ No

Cough: ☐ Yes ☐ No

Shortness of breath / breathing difficulty: ☐ Yes ☐ No

Fatigue / tiredness: ☐ Yes ☐ No

Runny / Watery discharge from the nose: ☐ Yes ☐ No

Sore throat: ☐ Yes ☐ No

Loss of taste and/or smell: ☐ Yes ☐ No

4. Was the proposed insured hospitalized? ☐ Yes ☐ No

If yes: a. Duration of hospitalization: b. Was the proposed insured admitted to a hospital Intensive Care Unit? c. Was the proposed insured put on a ventilator? ☐ Yes ☐ No

If yes, for how long? d. Date of final discharge:

Please e-mail the completed form to Brad Kadelski · brad@brookfieldpartners.com

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5. Is the proposed insured fully recovered? ☐ Yes ☐ No

If yes, date of recovery:

6. Does the proposed insured have any residuals? ☐ Yes ☐ No

If yes, please explain:

7. Was this a single occurrence of COVID-19, or re-occurrence?

☐ Single ☐ Re-occurrence

If re-occurrence, please list complete details:

8. Has the proposed insured been vaccinated for COVID-19 (Coronavirus)? ☐ Yes ☐ No

If yes, date of vaccination (date of 2nd shot if 2 were required):