HEALTH QUESTIONNAIRE FORM - GROUP LIFE

(Attach valid and clear copy of CNIC)

EMPLOYER INFORMATION

Name of Employer: _____ Name of Contact Person & Designation: _____

Contact Detail: Contact No.: _____ / Email ID: _____

Employer Address: _____

_____

EMPLOYEE INFORMATION

Name of Employee: _____

Name of Father / Husband: _____

DOB: _____ Gender: _____ Marital Status: _____

CNIC No. : _____ Contact No.: _____

Correspondence Address:

_____

_____

Date of Joining: _____ Designation: _____

Employee ID: _____ Annual Income: _____ (PKR)

Briefly describe your exact daily duties:

_____

_____

AVOCATION DETAILS

(Please provide detail to any of the below question marked as "YES")

1) Have you ever in the past been, or currently, involved in any Legal, Religious and Political Activity or are you engaged or ever had any involvement in any Civil or Criminal Litigation or Police case?	Yes / No
2) Are you involved or intend to involve in any of the dangerous / hazardous activities?	Yes / No
3) Does your travelling involve exposure to high risk areas as defined by local and internatio -nal- authorities?	Yes / No
4) Has any Insurance/Takaful proposal on your life ever been postponed or declined or is any proposal for your life, accident or disability on your life pending for decision with any insurer?	Yes / No

HEALTH & MEDICAL DETAILS

(Please provide detail to any of the below question marked as "YES")

Height _____ **Feet / Inches** **Weight** _____ **Kgs / Lbs**

Have you noticed any weight change in last 12 months? If 'Yes', please give variation with reason.

_____

Tobacco Yes / No **Alcohol** Yes / No **Drugs / Medicines** Yes / No

If yes, please specify quantity:

1. Are you presently in good health and not suffering from any of the Following?		v. Liver disease (Hepatitis A, B, C, D, E, Jaundice etc.)?	Yes / No
i. High Blood Pressure, Diabetes Mellitus, any endocrine disease?	Yes / No	vi. Disease of Kidney (Stone, Infection, Dialysis etc.), any disorder related to Genito- Urinary System?	Yes / No
ii. Heart ailments (Angina, Chest pain, Heart attack, Coronary Artery or Valvular disease etc.)?	Yes / No	vii. Disease of eye, ear, nose and throat?	Yes / No
		viii. Any form of tumor, growth, cancer etc.?	Yes / No
iii. Respiratory disease (Asthma, Tuberculosis, Chronic respiratory or lung disease etc.)?	Yes / No	ix. Any hereditary/ congenital / autoimmune disease etc.?	Yes / No
iv. Disease of nervous system and mental disorder (Epilepsy, Alzheimer, Anxiety, Depression, Chronic Headache, Paralysis, Stroke etc.)?	Yes / No	x. Any serious infection/ Sexually Transmitted Disease (STD), Human Immuno-Deficiency Virus (HIV), Acquired Immuno-Deficiency Syndrome (AIDS) etc.?	Yes / No

2. Have you ever suffered from any physical or mental illness/medical ailment (Pre-existing condition) or any Deformities?	Yes / No	**For Females only:**	
3. Have you consulted any doctor in the last 3 years for any reason other than routine health check-up with normal results, seasonal illnesses or flu?	Yes / No	**1. Are you pregnant? (If yes, please specify duration in months)**	Yes / No
		2. Do you have or ever had any obstetrical / Gynecological disease?	Yes / No
4. Have you ever suffered from any illness, injury, operation of any kind not mentioned above?	Yes / No		

DETAILS: (Injury/Disease, Date, Duration & Name of hospital visited)

DECLARATION AND AUTHORIZATION

I/We hereby declare that the information provided in the form are true and complete to the best of my/our knowledge, belief, and record. I also hereby authorize TPL Life Insurance Limited in order to seek information from any doctor, hospital, laboratory, my employer, any other organization or person that has any record information or acknowledge of my health/treatment and from my life Assurance/Takaful office to which a proposal on my life has any time been made, and the giving of such information.

I have checked and found all answers correct of above provided information which are not even in my own hand writing. I further agree that any misrepresentation or non-disclosure of facts will make my insurance coverage null and void since inception.

Employee Signature	Employer Signature & Stamp
DD / MM / YYYY	DD / MM / YYYY
Date	Date

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