TPL LIFE INSURANCE LIMITED

33-C, Shahbaz Commercial Area, Lane # 4, Phase-6, D.H.A, Karachi
Land Line: +92 21 35171701-24 (Ext: 161 & 162)

Health Questionnaire Form (HQF)

This questionnaire is to be filled by the employee. Please use Ball Point. Use of correction fluid or overwriting will render the form invalid and fresh form will be required. Any alteration must be signed by the employee.

Name of Employee (In Block Letters):			
Son of / Daughter of / Spouse of:			
Employee's Designation:		**Description of Duties:**	
Date of Birth:		**Employee's CNIC:**	
Height (FT)		**Weight (LBS)**	
Cell / Phone Nos.		**Email Address:**	
To be Enrolled under "Plan"		**Effective Date:**	
Employer's Name & Address:			

FAMILY MEMBERS TO BE COVERED (Please use additional sheet if necessary)

(Name in Block Letter)	Relation	Date of Birth	Height (Ft)	Weight (Lbs)	Occupation

(Please read the following questions very carefully and answer each question by ticking in the appropriate boxes. If the answer to any question is "YES", please give full details disclosing all material facts & attach copies of reports investigations as they can influence the assessment and acceptance of the application. If you are in any doubt as to whether any fact is material, you should disclose it, as failure to do so may invalidate a future claim.)

Q.1. Please provide the name and address of your usual Family Physician(s), If any. Name of Doctor:_____	**Yes**	**No**	**Q.2.** If you (or any family member to be insured) have seen any Attending Physician in connection with your physical or mental health within the last 3 years, please provide his/her name and address and reasons for consultation.	**Yes**	**No**
Q.3. Has any of your immediate family members (mother, father, brother and sister) suffered from heart disease, stroke, hypertension, cancer, kidney or diabetes or hereditary/familial disorder before age of 65?	**Yes**	**No**	**Q.4.** Do you smoke tobacco or drink alcohol? If so, please state daily consumption of tobacco and or weekly intake of alcohol?	**Yes**	**No**
Q.5. Have you (or any family member to be insured) had the following:					
5.1 Heart disease including structural defects and murmurs?	**Yes**	**No**	**5.2.** High blood pressure or disease of the blood vessels or circulatory system including varicose veins?	**Yes**	**No**
5.3 Stroke or disorder of the brain?	**Yes**	**No**	**5.4** Diabetes, thyroid disorders or gout?	**Yes**	**No**
5.5 Anemia or disorder of the blood?	**Yes**	**No**	**5.6** Kidney disease including disease of the bladder and any disorder of the reproductive system such as endometriosis, fibroids, ovarian cysts?	**Yes**	**No**
5.7 Cancer, tumour or abnormal growth?	**Yes**	**No**	**5.8** Respiratory disease or lung disorder?	**Yes**	**No**
5.9 Mental or nervous disorder?	**Yes**	**No**	**5.10** Paralysis, tremor, numbness, double vision, giddiness or disorder of the central nervous system?	**Yes**	**No**
5.11 Eye, ear, nose or other throat disorder?	**Yes**	**No**	**5.12** Back pain including any muscular problem or disorder of the bones or joints?	**Yes**	**No**
5.13 Digestive problems or disorder of the gall bladder or pancreas?	**Yes**	**No**	**5.14** Liver disease including hepatitis B & C carrier status?	**Yes**	**No**
5.15 Skin disease	**Yes**	**No**			
Q.6. Have you (or any family member to be insured) had or been advised by a physician to have medical treatment or surgery for any other physical ailment not already described in Questionnaire?	**Yes**	**No**	**Q.7.** Have you (or any family member to be insured) ever been tested positive for HIV/AIDs or any other sexually transmitted disease, or are you awaiting the results of such a test?	**Yes**	**No**
Q.8. Have you (or any family member to be insured) undergone any type of special investigation such as CT Scan, MRI, or surgical operation within the last 3 years?	**Yes**	**No**	**Q.9.** Are you (or any family member to be insured) currently taking any treatment or medication or awaiting medical investigations, laboratory test, treatment or surgery?	**Yes**	**No**
Q.10. Have you, your spouse or any of your children suffered or suffering from any congenital disease (disease present since birth)? And are under treatment.	**Yes**	**No**	**Q.11.** Have you (or any family member to be insured) been absent from work due to medical reasons for a continuous period of a week or more during the last 3 years?	**Yes**	**No**
Q.12. Are you/or your spouse pregnant now?	**Yes**	**No**			

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PLEASE GIVE DETAILS OF ANY "YES" ANSWERS TO THE ABOVE QUESTIONS

Question No.	Patient Name	Disease	Date of Illnes	Duration of Illness	Result	Name & Address of Attending Doctor / Hospital

DECLARATION & AUTHORIZATION

I hereby declare that what has been stated above is true and complete and the best of my knowledge and belief. I have not withheld any material information and that it is understood and agreed that this declaration the application of my employer to the TPL Life Insurance Limited are the basis for the Group Hospitalization Insurance cover applied for, and that any non-disclosure or misrepresentation of facts will make my/our insurance cover void since inception.

I hereby authorize any hospital, physician, or surgeon who has or may attended to me or my family to furnish to the TPL Life Insurance Ltd. with any information they may require concerning my/our medical history or examinations

Signature of Employer
with official Seal

Signature of Employee
for Self & on Behalf of Dependent

Signed Date:_____

FOR OFFICIAL USE ONLY FOR TPL LIFE INSURANCE LIMITED

Approved:

1	Basic Hospitalization	☐	Standard	☐	Substandard	☐	Extra Morbidity	☐
2	Maternity	☐	Standard	☐	Substandard	☐	Extra Morbidity	☐
3	Major Medical / Dread Diseases	☐	Standard	☐	Substandard	☐	Extra Morbidity	☐

If Substandard, due to following reasons:

1	
2	
3	
4	
5	

Any other remarks:	

Underwritten By:

Date: