HEALTH QUESTIONNAIRE FORM

Health ID. # _____
(For office use only)

Name of Employee : _____ **Gender: Male** ☐ **Female** ☐
(Please write in CAPITAL Letters)

S/O, D/O, W/O : _____ **C.N.I.C. No. :** _____

Name of Employer: _____ **Designation:** _____ **Date of Joining:** _____

Employer's Address : _____ **Employer's ID.** (If any) _____

Residential Address : _____

Tel. (Off) : _____ **Tel. (Res.)** _____ **Cell No. :** _____

Please list Family Members (Spouse, Son, Daughter, Mother and Father) to be covered: Attach additional sheets, if necessary

Name of Employee/ dependants (Please write in CAPITAL Letters)	Relationship with Employee	Date of Birth (dd/mm/yyyy)	For Official Use
1-	Self		
2-			
3-			
4-			
5-			
6-			
7-			
8-			

Kindly answer the following questions by ticking the appropriate answer:

	YES	NO
1) Have you or any member of your family (spouse/children/parents) currently or at any time prior to applying for takaful coverage/insurance :		
a) Suffered from any medical condition / disease / illness or injury	☐	☐
b) Been aware of any medical condition /disease / illness or injury (even if no doctor was consulted)?	☐	☐
c) Received diagnosis from a doctor / Hakim or Homeopath (even if no treatment was provided)?	☐	☐
d) Been taking or been advised to take any medication for more then 7 continuous days?	☐	☐
e) Suffered from any physical or mental disability?	☐	☐
2) Do you or any member of your family smoke any form of tobacco or consume alcohol?	☐	☐
3) Are you and all members of your family (listed above) in good health?	☐	☐
4) Is your spouse / your self,(if you are a married female employee) pregnant? If yes, how many month's?	☐	☐

If you have answered "YES" to any of the question 1)a. to 1)e. above, please provide details below: *Attach additional sheets, if necessary*

Please attach photocopies of the relevant medical reports.

Name of the Employee /Dependantfor whom YES answer has been given	Please describe medical condition(s), treatment received, investigation undertaken and results. Is any further tests or treatment suggested or required?	Attending Doctor (Hospital's Name & Address)

DECLARATION:-

I hereby declare that the details contained in this form are true and correct to the best of my knowledge and belief and I have not concealed, misrepresented or misstated any material fact. I understand that this health declaration form together with the application of my Employer to Takaful Pakistan Ltd. are the basis for Group Health coverage applied for. I hereby authorize any hospital, physician or surgeon who has attended to me or my family members to furnish to Takaful Pakistan Limited with any and all information that they may require concerning our medical history and/or examinations.

TO BE FILLED BY THE EMPLOYER.
Please specify the Plan for this employee / family:

A ☐ B ☐ C ☐

D ☐ E ☐ Other _____

Coverage Effective Date: _____

Employer's Signature & Stamp

_____ **Employee's Signature**

_____ **Date**

Takaful Pakistan Limited
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