Group Family Takaful Scheme
Health Questionnaire

To be completed by proposed ***Investors/Participant***

Group Family Takaful Policy No | | | | | | | | | | | | | | | | | | | | Customer ID. _____

PERSONAL DETAILS

Name of Investor / Participant | Date of Birth

Father's/ Husband's Name | Sex Male ☐ Female ☐

CNIC No (attach copy) | Mobile No.

Residential Address

Present Occupation: Salaried ☐ Business ☐ Professional ☐ Agriculture ☐ Other ☐ | Education

Employer's/Business Name | Email Address

Employer's/Business Address

Designation / Job Title | Exact Daily Duties | Office No.

Annual Income (Approx) | Account Opening Date ☐☐ ☐☐ ☐☐ | Account No.

Branch | Customer ID.

Amount of Cumulative Investment Rs. ☐☐☐☐☐☐☐☐☐☐ | Investment Term ☐☐ Years

MEDICAL DECLARATION

Height ☐☐☐ Ft-In/ Cm Weight ☐☐☐ Kg/ Lb

		Yes	No
1.	Are you to the best of your knowledge in good health and entirely free from any mental or physical impairment or deformatiy?	☐	☐

If you answer "yes" to any of the below questions, please give complete details (including dates, duration and treatment, names and addresses of physician) in space provided below for Additional medical information. Use a seperate sheet if neccessary. Also, attach copies of relevant medical reports.

2.	Have you ever suffered or do you now suffer from:		
a.	diabetes, high blood pressure, heart disease or arteriosclerosis ?	☐	☐
b.	diseases of the respiratory system (e.g. Asthma, Tuberculosis), gastrointestinal system (e.g. Hepatitis, liver disorder, digestive disorder), genito-urinary system (e.g. renal stones, infection of kidneys / urinary or genital organs, venereal diseases), nervous system or mental disorder (e.g. epilepsy, fits, frequent headaches)?	☐	☐
c.	any form of tumor, growth, cancer or any diseases of the blood, glands, spleen, ears, eyes or skin?	☐	☐
d.	any other diseases or ailments not mentioned above?	☐	☐
e.	AIDS, AIDS related Complex (ARC) or an immune system disorder?	☐	☐
3.	History of past, present or advised hospital admission or surgery?	☐	☐
4.	Do you take regular medications for treatment or control of any condition or ailment or disability?	☐	☐
5.	Have you consulted a physician for any reason, including routine examinations and blood tests, or have you received any blood transfusions within the past 5 years?	☐	☐
6.	Are you unable to work full time because of any disorder or disability ?	☐	☐
	For Females Only		
7.	Are you pregnant? or have you ever had any gynecological, obstetrical or breast disease / medical condtion?	☐	☐

Additional Medical Information

The foregoing statements and answers are full, complete and true. I agree that they shall be the basis of Takaful coverage for me under Group Family Takaful Policy, EFU Life Assurance Ltd - Window Takaful Operator shall not be liable for any claim on account of illness, injury or death, the cause of which was known prior to approval of my request for Takaful coverage and with held or concealed in above statements. I authorize any physician, nurse or hospital employee to disclose to EFU Life Assurance Ltd - Window Takaful Operator any and all information regarding mymedicalhistory.

I understand that concealment of material facts listed above can lead to repudiation of my claim.

Place: _____ Date: _____ Signature of Investor / Participant: _____

DECLARATION BY THE POLICY HOLDER / FINANCER / EMPLOYER

I/We hereby confirm that the information provided above is true to the best of our knowledge, belief and record. I/We also confirm having read and understood the terms of Master Participant Membership Document (PMD), and also understand that such benefits are payable subject to and in accordance with the terms of the Master Participant Membership Document (PMD), where applicable.

Date: _____ Signature of Al-Meezan Representative: _____

Please affix official Al-Meezan stamp / seal

The Takaful Coverage to be provided under this Health Declaration will be a reducing term coverage, which means no maturity benefit is payable

EFU LIFE ASSURANCE LTD - Window Takaful Operator
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