



PAK-QATAR FAMILY TAKAFUL
Together for Better

Group Family Takaful Scheme Health Questionnaire

To be completed by *Investors*



Section 1: PERSONAL INFORMATION

Mr. Mrs. Miss Name: _____

Date of Birth: _____ CNIC Number: _____ Contact No: _____

Residential Address: _____

Title of Business: _____ Office Telephone: _____ Fax No: _____

Designation: _____ Exact Daily Duties: _____ Email Address: _____

Office Address: _____

Account Opening Date: _____ Account Number: _____ Customer ID: _____

Type of Investment Account: Meezan Mahana Kharch Account Meezan Tahaffuz Pension Fund Meezan Cash Fund


Investment Amount in (Rs.): _____ Term: _____

Investment Amount in (Rs.): _____ Term: _____

Investment Amount in (Rs.): _____ Term: _____

Height: _____ feet / _____ inch Weight: _____ Kg / _____ Lbs Do you use tobacco or alcohol? No Yes Specify quantity _____

Section 2: MEDICAL DECLARATION (to be completed by proposed investor).

 Before returning this form to your bank, please fold and staple the bottom half of the form to this line to conceal your answers to the medical questions below.

Provide details for any "Yes" answers below. Use a separate sheet if necessary.

1 Have you had any injury, sickness, or ailment, or have you consulted or been treated by a healthcare provider for any reason in the past five years? Yes No

2 Have you ever had:

A. High Blood Pressure, Heart Disease, or Arteriosclerosis? Yes No

B. Mental Illness, Stroke, or Epilepsy? Yes No

C. Cancer, Diabetes, or Nephritis? Yes No

D. Any problem with the back or spine? Yes No

E. Acquired Immune Deficiency Syndrome (AIDS), AIDS related Complex (ARC) or an immune system disorder? Yes No

3 Are you now unable to work full time because of any disorder or disease? Yes No

4 Do you take regular medication for Treatment or Control of any condition or ailment? Yes No

5 Do you contemplate any operation or visit to a doctor for an existing injury or ailment? Yes No

6 During the last 2 years, have you been involved in any type of hazardous occupation or avocation? Yes No

For Females only: Are you pregnant, or have you ever had any gynecological, obstetrical or breast disease / medical condition? Yes No

Injuries, Disease, Disorders & Operation	Month, Year	Duration	Result	Name and Address of Health Care Providers consulted
Example. Road Traffic Accident	January, 2001	3 days hospitalization	Fracture	Dr. Saleem, AKUH, Karachi

Authorization and Declaration - Please read and sign below:

I hereby certify that all answers to questions appearing on this form are true and complete to the best of my knowledge and belief.

For Underwriting and claim purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, other medical or medically related facility, takaful/ insurance company, or employer to give Pak-Qatar Family Takaful Limited or its authorized representative ALL INFORMATION on my behalf including copies of records with reference to any sickness, accident disability, treatment, examination medical investigation, advise or hospitalization underwent.

I hereby apply for the Family Takaful coverage under the terms and conditions of the master Participant Membership Document. In case, if the basis of coverage is Contributory, I certify that I shall pay the contribution mentioned above to the participant discontinuation of which terminates my takaful cover automatically. In case however, if the basis of coverage is Non-Contributory, I certify and know that the discontinuance of Takaful Contribution by the participant on my behalf to the Takaful Company will terminate my Family Takaful over automatically.

A photocopy of this form will be as valid as the original.

Date of Statement: _____ / _____ / _____
Day Month Year

Investor's Signature

Please affix your signature as on CNIC

Declaration by the Policyholder/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 of Statement: _____ / _____ / _____
Day Month Year

Bank's Representative
Signature

Please affix official stamp/seal with signature