



Family Health Questionnaire Form (FHQ)

Cert ID
(If already issued)

INSTRUCTIONS: It is very important that complete medical history is disclosed in this form. Please note that if a pre-existing medical condition/illness is NOT DISCLOSED, we can decline the claim relating to it. If the medical condition is disclosed, we may cover that medical condition. Therefore, it is in your best interest to disclose complete medical history.

NOTE: CNIC / Passport No. (in case of foreigner) is mandatory for Employee, Spouse, Parents and Children (for above 18 year of age)

"Pre-Existing Medical Condition" means any sickness, illness, disease, injury, symptom, co-morbid condition or the underlying cause, condition, sickness, illness, disease, injury or risk factors of an illness or any disease that causes another illness due to direct or indirect impact, has been known, was treated, is under treatment, any treatment required or has been investigated even if no medical advice or diagnosis or treatment was sought, prior to applying for insurance.

Name of Employee: Gender: Employee ID
In CAPITAL letters First / Middle / Given Name(s) Male/Female (If any)

Employer Name: Designation: Joining Date: Marital Status

Home Address: Marriage Date

Subsidiary/ Location (If any) Nationality CNIC No. / Passport No. Date of Birth

Bank Name IBAN No. Cell No. Email ID

Please list Family Members (spouse, son, daughter, mother and father) to be covered: *Attach additional sheets if necessary. In case of addition of newborn child or spouse, please attach copy of Birth Certificate for the child and copy of Nikahnama / Marriage Certificate for the spouse.*

S. No.	NAME Please write in CAPITAL letters	Relationship with You	Date of Birth (dd/mm/yy)	Height (ft./in)	Weight (lbs)	CNIC No. / B Form No. (Mandatory)
1.						
2.						
3.						
4.						
5.						

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Are / have you or any member of your family (spouse/children/parents) currently or at any time prior to applying for insurance: | | |
| a. Suffered from any medical condition /disease / illness or injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Aware of any medical condition / disease / illness or injury (even if no doctor was consulted)? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Received diagnosis from a Doctor / Hakeem or Homeopath (even if no treatment was provided)? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Taking or been advised to take any medication for more than 7 continuous days? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Suffered from any physical or mental disability? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you or any member of your family smoke any form of tobacco or consume alcohol? if yes, how much? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you and all members of your family (listed above) in good health? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. a. Is your spouse (or yourself, if you are a female) pregnant? If yes, how many months? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Please mention last delivery date (if any). | <input type="checkbox"/> | <input type="checkbox"/> |

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 Person whom 'Yes' answer has been given	Please describe medical condition and its duration, treatment received, investigations undertaken and results. Is any further tests or treatment suggested or required?	Attending/treating Doctor (Name, Address & Hospital)

DECLARATION: I hereby declare that the statement above is true and complete to the best of my knowledge and belief. I have not withheld any information. I understand that this health declaration form together with the application of my employer to EFU Life Assurance Ltd. are the basis for the Group Health Insurance applied for. I hereby authorize any hospital, physician or surgeon who has attended to me or my family members to furnish to EFU Life Assurance Ltd. with any and all information that they may require concerning our medical history and/or examinations. I understand that any false, incorrect, incomplete or misleading statement may invalidate my participation in this group health policy.

TO BE FILLED BY THE EMPLOYER

Please specify the plan for this employee

Executive Deluxe Standard

Value Basic

Other _____

Coverage Effective Date: _____

Signature of Employee for Self & on behalf of family members being covered _____

Date _____

Signature & Stamp of the Employer

EFU LIFE ASSURANCE LTD.

Health Office: 37-K, Block-6, PECHS, Karachi-75400.

Please fill in English only