Pak-Qatar Family Takaful Limited

PAK-QATAR FAMILY TAKAFUL
Together for Better

Head Office: Suite No. 102-105, Business Arcade, P.E.C.H.S., Block -6,
Main Sharea Faisal, Karachi-75400, Pakistan
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Group HEALTH FAMILY TAKAFUL

Scheme No	Cert. No.	R&B Limit

Family Health Questionnaire

- To be completed by the **eligible Employee** only.
- **Please be informed that complete medical history should be disclosed in this form. Please note that if a pre-existing medical condition(s) not disclosed, PQFT will always reserve the right to decline the claim directly or indirectly relating to it.**
- Group Health Takaful Coverage for each proposed Individual Covered shall only be effective on written notification from Pak-Qatar Family Takaful Limited after receipt of this Questionnaire.

Title of Participant (Company					
Name of Employee:				**Employee No:**	
CNIC Number		**Date of Birth**	/ /	**Gender**	☐ Male ☐ Female
Date of Joining	/ /	**Date of Confirmation**	/ /	**Marital Status**	☐ Single ☐ Married
Exact Daily Duties				**Designation**	
Residential Address					
Residence Phone		**Residence Phone**		**Mobile Number**	

Please provide details of eligible dependent (Spouse, Son & Daughter), proposed for Health Takaful coverage, Attach addition sheet, if required.

Name (In CAPITAL LETTERS)	Date of Birth (dd-mm-yyyy)	Gender (M/F)	CNIC Number (#####-#######-#)	Relationship With Employee	Marital Status	In Good Health?
						☐ YES ☐ NO
						☐ YES ☐ NO
						☐ YES ☐ NO
						☐ YES ☐ NO
						☐ YES ☐ NO

HEALTH DECLATIOATION

1) **Have you or any proposed member of your family currently or at any time prior to applying for Takaful coverage;**
   a. Suffered from any medical condition(s), disease(s), illness (es) or injury (ies)? ☐Yes ☐No
   b. Aware of any medical condition, disease, illness or injury (whether consulted with doctor or not)? ☐Yes ☐No
   c. Received diagnosis from a Doctor or Hakeem or Homeopath (even in no treatment was provided)? ☐Yes ☐No
   d. Suffered from any physical or mental disability? ☐Yes ☐No

2) **Have you or any proposed member of your family ever suffered from high blood pressure, heart disease, diabetes, shortness of breath, cancer, tumor or growth, jaundice, fits or convulsions, pain in chest, paralysis, lung or kidney disorders, nervous or psychiatric disorders?** ☐Yes ☐No

3) **Have you or any proposed member of your family contemplate any surgery/operation or suffering from any other illness or disabilities that may require treatment and have not already been disclosed or mentioned above?** ☐Yes ☐No

4) **Do you or any member of your family currently taking medication of any kind to control of any medical condition or ailment?** ☐Yes ☐No

5) **Is your spouse (or yourself, if you are a female) pregnant?** If "YES", how many months _____)? ☐Yes ☐No

If "Yes" to any questions 1-5 above, please provide details in following space. Use a separate sheet if necessary.

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 test of treatment suggested or required?	Attending/Treating Doctor (Doctor's Name, Hospital Name, Address, Phone No.)

DECLARATION & AUTHORIZATION

I hereby certify that all answers to questions appearing on this form are true and complete to the best of my knowledge and belief. I am also aware that subject to the terms of acceptance of my coverage, this declaration & authorization together with the master Participant Membership Document (PMD) shall form the contract between participant and Takaful service provider. I authorize any doctor , hospital,, clinic, or medical service provider, takaful/insurance company, or any other institution, or any person, who has any information or record about me and/or any of my dependents to provide **Pak-Qatar Family Takaful Limited** with the complete information including copies of their records with reference to any sickness, accident, disability, any treatment, examination, medical investigation, advice of healthcare provider,. Photocopy of this authorization shall be valid as the original.

Date of Statement / /

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

To Be Filled by Employer

Takaful Plan/Category (Please refer PMD for details)		**Start Date of Individual Coverage*** (Risk Assessment date or date of Statement, whichever is later)	/ /
Basis of Membership	☐ **Non-Contributory** (Employer donating Contribution) ☐ **Contributory** (Employer and Employee both Contributing)		

Verification by Participant/Employer

I/We hereby certify that all answers to questions appearing on this form are true and complete to the best of my/our knowledge and belief.
We understand and agree that the above statement shall form the basis for Takaful coverage.

Date of Verification / /

_____
Signature & Stamp of the Participant/Employer