Alfalah Insurance

HEALTH DECLARATION FORM

(PLEASE USE BLOCK LETTERS)

Name of Employee: _____ Employee DOB: _____ Employee ID: _____

S/O, D/O, W/O: _____ Employee CNIC: _____ Plan: _____

Designation: _____ Tel / Cell #: _____ Branch: _____

Name of Employer: _____ Effective date of coverage: _____

FAM ILY MEMEBRS TO BE COVERED : (Please note that names & ages provided by you in this form will appear on your insurance letter / card)

Name of Family Members (Please use CAPITAL letters	Relationship with Employee	Gender M/F	DOB (dd/mm/yyyy)	Weight (KG)	Height (Feet)	For official Use only

IMPORTANT: Please ensure that all questions are answered "YES" or "NO". Do not leave any question unanswered. Any question left blank / unanswered will be considered as "YES"

DESCRIPTION	YES	NO
Has any member of your family (wife/children/parent) expired due to any of the following? (Please tick the relevant condition and the relevant person)? 1) Any Form of Cancer. 2) Heart Disease/Disorder. 3) Diabetes Mellitus. 4)Stroke / Paralysis 5) Kidney Disease. 6) Abnormal Blood Pressure. 7) Liver Disease. 8) COPD/ Asthma 9) Any disease not mentioned here	☐	☐
Have you or any member of your family to be covered been admitted to a hospital in the last 5 years due to any disease/surgery/investigations?	☐	☐
Have you or any member of your family to be covered consulted a specialist doctor for the treatment of long standing disease within the past 5 years? If yes, give details of the Illness/treatment.	☐	☐
Do you or any member of your family (wife/children/parent) suffer to any of the following ?(please tick the relevant condition) 1) Any Form of Cancer. 2) Heart Disease/Disorder. 3) Diabetes Mellitus. 4) Stroke / Paralysis 5) Kidney Disease. 6) Abnormal Blood Pressure. 7) Liver Disease/ Hepatitis. 8) High Cholesterol 9) COPD/ Asthma. 10) Dengue Fever 11) Any disease not mentioned here	☐	☐
Do you or any member of your family to be covered is a smoker? If yes, how many cigarettes a day _____?	☐	☐

Please give the details below if you have indicated any 'YES' above. Please use extra sheets, prescriptions/supporting documents explaining any condition/medial history with this form.

Name	Medical Condition	Duration	Result / Treatment	Name / Address of attending doctor / hospital

DECLARATION: I hereby declare that what has been stated above is true and complete to the best of my knowledge and belief and I have not withheld any information. I hereby agree that any non-disclosure or false statement will lead my/ our health insurance coverage void from inception. I hereby authorize any hospital, physician or surgeon who has attended me or my family to furnish to the Alfalah Health Insurance, with any information that they may require concerning our medical history or examinations.

Signature of the Employee (for self & on behalf of dependents) Signature of the Employer (with official seal)

Date: _____ Date: _____

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