HEMAYAH
EFU FAMILY TAKAFUL

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 takaful.

Name of Employee: _____ (In CAPITAL letters; First / Middle / Given Name(s)) Gender: _____ (Male/Female) Employee ID _____ (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 takaful:		
a. Suffered from any medical condition /disease / illness or injury?	☐	☐
b. Aware of any medical condition / disease / illness or injury (even if no doctor was consulted)?	☐	☐
c. Received diagnosis from a Doctor / Hakeem or Homeopath (even if no treatment was provided)?	☐	☐
d. Taking or been advised to take any medication for more than 7 continuous days?	☐	☐
e. Suffered from any physical or mental disability?	☐	☐
2. Do you or any member or your family smoke any form of tobacco or consume alcohol? if yes, how much?	☐	☐
3. Are you and all members of your family (listed above) in good health?	☐	☐
4. a. Is your spouse (or yourself, if you are a female) pregnant? If yes, how many months?	☐	☐
b. Please mention last delivery date (if any).		

If you have answered "YES" to any of the question 1)a. to 1)e. above, please provide details below: *Attach additional sheets if neccessary*

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-Window Takaful Operations are the basis for the Group Health Takaful 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-Window Takaful Operations 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 health takaful contract.

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

TO BE FILLED BY THE EMPLOYER

Please specify the plan for this employee

☐ A Executive ☐ B Deluxe ☐ C Standard
☐ D Value ☐ E Basic

Other _____

Coverage Effective Date: _____

Signature & Stamp of the Employer

EFU LIFE ASSURANCE LTD.
WINDOW TAKAFUL OPERATIONS

Please fill in English only

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