HEALTH QUESTIONNAIRE & INSURANCE APPLICATION

Note: Don't leave any blanks, unanswered questions, dates /signatures and attach medical reports wherever applicable.

Jubilee LIFE INSURANCE

1. Details of Proposed Insured / Applicant :

Name of the Life Proposed / Applicant :		Sex :	☐ Male	☐ Female
Father's / Husband's Name :		Date of Birth :		
CNIC Number :	Marital Status :	☐ Single	☐ Married	☐ Widowed ☐ Divorced
Residential Address:				
E-mail Address:				
Personal Physician's Name and Address:				

2. Details of Occupation :

Status : ☐ Employed ☐ Self-Employed ☐ Business ☐ Other please specify

Name of Company / Employer :	Group Policy No. :
Designation :	Exact Daily Duties :
Average Annual Earned Income (Salary plus other sources)	
Occupational Address :	
E-mail Address :	Telephone No.: Mobile :

3. Medical History :

3.1	What is your height? _____ ft./cms	How much do you weigh? _____ lbs/kg.	
3.2	Have you ever lost or gained your weight in past years?	☐ Yes	☐ No
3.3	Do you smoke or drink alcohol? : (Please state your normal daily or weekly consumption of cigarettes, cigarillos, cigars or pipe, beer, wine or spirits)	☐ Yes	☐ No
3.4	Have you ever had or been diagnosed with any of the following :		
a)	high blood pressure, chest pain, stroke or any heart or circulatory trouble?	☐ Yes	☐ No
b)	enlarged glands or any form of cancer, tumour or disorder of the blood?	☐ Yes	☐ No
c)	diabetes mellitus or any disorder of the kidneys, liver or bladder?	☐ Yes	☐ No
d)	any disorder of the stomach or bowels?	☐ Yes	☐ No
e)	any disorder of the joints or vertebral column?	☐ Yes	☐ No
f)	shortness of breath, asthma, bronchitis or any disorder of the lungs?	☐ Yes	☐ No
g)	epilepsy, fits or fainting attacks, frequent headaches, nervous breakdown?	☐ Yes	☐ No
h)	any illness, injury, disability or hospitalization not mentioned above? (If so, please give details (date, duration, treatment, name / address of the Physicians)	☐ Yes	☐ No
3.5	Are you presently taking medication of any kind? If so, please give full particulars.	☐ Yes	☐ No
3.6	Have you ever been counselled or medically advised or treated in connection with an H.I.V. infection, AIDS or any sexually transmitted disease? If so, please give full particulars.	☐ Yes	☐ No
3.7	Have you ever consulted a physician for any reason, including routine examinations and blood tests, or have you received any blood transfusions within the last 5 years?	☐ Yes	☐ No
3.8	Have you ever taken drugs other than those prescribed by a doctor? If so, please give details (date, duration, type of drugs).	☐ Yes	☐ No
3.9	Have any of your natural parents, brothers, sisters died or suffered before age of 60 from diabetes mellitus, heart diseases, cancer, stroke, multiple sclerosis, mental or neurological disorders? If so, please give details (age if living, present state of health, age / cause of death).	☐ Yes	☐ No
3.10	For female only: Are you pregnant? Or have you ever had any gynecological, obstetrical or breast disease/medical condition	☐ Yes	☐ No

4. Activities :

4.1	Do you participate or intend to participate in any hazardous pursuits or activities (e.g., diving, motor racing, aviation)? If so, please give details (e.g., diving depth, type of vehicle, type of aircraft).	☐ Yes	☐ No
4.2	Do you perform any hazardous occupational activities or foreign travels, stays? If so, please give details (e.g., exact type of hazard, name / region of the country).	☐ Yes	☐ No
4.3	Do you have any enmity or are you presently engaged in any litigation in any court of law?	☐ Yes	☐ No
4.4	a) Have you any life assurance or accidental death, disability, critical illness covers in force?	☐ Yes	☐ No
	b) Have you applied for any other cover with another company at the time being?	☐ Yes	☐ No
	c) Has any application for life, accidental death, disability, critical illness covers ever been declined or modified in plan or rate? If so, please provide details. (sum assured, duration, reason for loading, Policy interest)	☐ Yes	☐ No

If yes to any of the above questions, please provide complete details with dates and supporting evidences.

Declaration and 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 authorize any doctor, hospital, clinic or medical service provider, insurance company, or any other institution, or any person, who has any record or information about me and/or any of my dependent to provide to Jubilee life Insurance Company Limited complete information including copies of records with reference to any sickness, accident, disability, treatment, examination, medical investigation, advice or hospitalization underwent. I hereby apply for the insurance coverage under the terms and conditions of the master policy documents. In case, if the basis of coverage is Contributory, I certify that I shall pay the contribution mentioned above to the policyholder, discontinuation of which terminates my insurance cover automatically, In case, however, if the basis of coverage is Non-Contributory, I certify and know that the discontinuation of payment of premium by the Policyholder on my behalf to the Insurance Company will terminate my Insurance cover automatically. A photocopy of this authorization shall be as valid as the original.

میں یہ تصدیق کرتا/ کرتی ہوں کہ میں نے جو کچھ اس فارم میں درج کیا ہے وہ بالکل صحیح ہے۔ کسی ڈاکٹر، ہسپتال، کلینک یا طبی، امداد فراہم کرنے والے کو، انشورنس کمپنی یا دیگر ادارہ، یا کسی شخص جو کہ میرے بارے میں کوئی ریکارڈ یا معلومات رکھتا/رکھتی ہو، کو اختیار ہے کہ وہ مکمل معلومات بمع ریکارڈ کی فوٹو کاپیوں جو کہ کسی بیماری، حادثہ معذوری کی علاج طبی چیک اپ، ہسپتال میں داخل ہونے کے ریکارڈ کے ساتھ جو بلی لائف انشورنس کمپنی فراہم کرے۔ میں نے ماسٹر پالیسی دستاویزات کی شرائط وضوابط کے تحت بیمہ کے لئے درخواست دی ہے اگر یہ بیمہ کونٹری بیوشن کی بنیاد پر ہے تو میں یہ تصدیق کرتا/ کرتی ہوں کہ میں پالیسی ہولڈر کو مذکورہ کنٹری بیوشن کی ادائیگی کروں گا/گی اور ادائیگی میں عدم تسلسل میرے بیمہ کو خود بخود ختم کر دیگا۔ اور اگر یہ بیمہ کنٹری بیوشن کی بنیاد پر نہیں ہے تو میں جانتا/جانتی ہوں کہ پالیسی ہولڈر کی میرے جانب سے انشورنس کمپنی کو پریمیئم کی ادائیگی میں عدم تسلسل بیمہ کو خود بخود ختم کر دیگا۔ اس اقرار نامہ کی فوٹو کاپی اصل کی مانند کارآمد ہوگی۔

Date of Statement: D D — M M — Y Y Y Y

Place of Statement:

Please affix your old signatures on CNIC, if different from present signature	
New	Old

Declaration by the Policyholder / Financer /Employer

I/we confirm that the information provided above is true to the best of our knowledge, belief and record. I/we agree to provide benefits for the eligible prospects under the Policyholder's Group Life Insurance Master Policy Document. I/we understand that such benefits are payable subject to and in accordance with the terms of the Master Policy where applicable. I/we agree to deduct the necessary contributions from the earnings of the covered persons under the policy and to forward them promptly to Jubilee Life Insurance Company Limited. This agreement shall cease to operate in respect of any person if he/she ceases to be member/employee of the class/group covered under the master policy from the date of such discontinuation or on such earlier date as agreed with the person concerned. In either case I/we undertake to notify the company accordingly.

Name of the Authorized Official

Designation of the Authorized Official

Date Signature and

Official Stamp / Seal

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