



**GROUP FAMILY TAKAFUL (LIFE)**  
Health Declaration Form



ICAP Registration #: \_\_\_\_\_

**SECTION 1 : BASIC DATA (to be completed by member)**

Name of Member:		Date of Birth _____ <small>Day Month Year</small>	
Father's Name/Husband Name:			
☑ Home Address:		☎ No. _____	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	CNIC No. _____	Marital Status	
Occupation		E-mail address:	
Title of Business		Exact daily duties	
Height _____ <small>feet inch</small>	Weight _____ <small>Kg Lbs</small>	Do you use tobacco or alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes _____ <small>Specify quantity</small>	

**SECTION 2 : MEDICAL DECLARATION (to be completed by member)**

*Provide details for any "Yes" answers below. Use a separate sheet if necessary.*

- During the past five years, have you had any "extra-ordinary" injury, sickness, or ailment, for which you consulted or been treated by a healthcare provider?  Yes  No
- Are you presently suffering from any of the following specific condition or ever had:
  - High Blood Pressure, Heart Disease, or Arteriosclerosis?.....⇒  Yes  No
  - Mental Illness, Stroke, or Epilepsy?.....⇒  Yes  No
  - Cancer, Diabetes, or Nephritis?.....⇒  Yes  No
  - Any problem with the back or spine?.....⇒  Yes  No
  - Acquired Immune Deficiency Syndrome (AIDS), AIDS related Complex (ARC) or an immune system disorder? ⇒  Yes  No
- Is the nature of your illness is such that it would have prevented you from taking up a full time employment?  Yes  No
- Do you take regular medication for treatment or control of any condition or ailment? ⇒  Yes  No
- Do you contemplate any operation or visit to a doctor for an existing injury or ailment? ⇒  Yes  No
- During the last 2 years, have you been involved in any type of hazardous occupation or incident? ⇒  Yes  No

**For Female only:** Have you ever had any gynecological, obstetrical or breast disease/medical condition? ⇒  Yes  No

Injuries, Diseases, Disorders & Operation	Month, Year	Duration	Result	Name and Address of Health Care Providers consulted



**Authorization and Declaration—please read and sign below:**

I hereby certify that all answers to questions appearing on this form are true and complete to the best of my knowledge and belief.

**For Underwriting and claim purposes,** I permit any physician or other medical practitioner, hospital, clinic, other medical or medically related facility, takaful/insurance company, or employer to provide **Pak-Qatar Family Takaful Limited** or its authorized representative **UNQUALIFIED ACCESS TO ALL INFORMATION** on my behalf including copies of records with reference to any sickness, accident disability, treatment, examination medical investigation, advise or hospitalization underwent.

I hereby **apply for the Family Takaful coverage** under the terms and condition of the master Participant Membership Document (PMD). In case of acceptance, I certify that I shall pay the contribution.

A **photocopy** of this form will be as valid as the original.

\_\_\_\_\_

Member's Signature

Please affix your signature as on CNIC

Day Month Year



**Declaration by ICAP – Benevolent Fund**

I hereby certify that all answers to questions appearing on this form are true and complete to the best of my knowledge ad belief.

\_\_\_\_\_

Authorized Signature  
ICAP

Day Month Year

If you need any kind of assistance in filling up this form, please contact:

Shakeel Ahmad  
Tel: 021-99251630 or 111-000-422 Ext.353