Adamjee Life Assurance Co. Ltd.
Window Takaful Operations
Registered Office: Office No. 505, 5th Floor,
ISE Towers, 55-B, Jinnah Avenue, Blue Area, Islamabad.
Principal Office: 3rd and 4th Floor, Adamjee House,
I.I.Chundrigar Road, Karachi - 74000.

Employee Health Questionnaire for Group Assurance

Name of Employer _____ Group Plan No. _____

Name of Investor/Participant_____ Date of Birth _____

Present Occupation _____ C.N.I.C NO: _____

TEL: (RES) _____ TEL: (OFFICE) _____ TEL: (CELL) _____

Height _____ Weight _____ Gain or Loss past Year _____

Personal Physician (Name and Address) _____

Sum of assured/covered amount _____

Terms (no of year's b/w 3 to 18 _____

	Yes	No
1) 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?	☐	☐
b) Enlarged glands or any form of cancer, tumour or disorder of the blood?	☐	☐
c) Diabetes mellitus or any disorder of the kidneys, liver or bladder?	☐	☐
d) Any disorder of the stomach or bowels?	☐	☐
e) Any disorder of the joints or vertebral column?	☐	☐
f) Shortness of breath, asthma, bronchitis or any disorder of the lungs?	☐	☐
g) Epilepsy, fits or fainting attacks, frequent headaches, nervous breakdown?	☐	☐
h) Any illness, injury or disability not mentioned above?	☐	☐
If so, please give details (date, duration, treatment, name/address of physicians) on the back signed by yourself.		
2) a) Are you presently taking medication of any kind?	☐	☐
b) 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 on the back signed by yourself		
3) Have any of your natural parents, brothers, sisters died or suffered before age 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) on the back signed by yourself.		
4) a) Have you any life assurance or accidental death, disability, critical illness covers in force?	☐	☐
b) Have you applied for any other cover with another company at the time being?	☐	☐
c) Have any application for life, accidental death, disability, critical illness covers ever been declined or modified in plan or rate?	☐	☐
If so, please give details (sum assured, duration, reason for loading, policy interest) on the back signed by yourself.		
5) Do you smoke?	☐	☐
If so, please state your normal daily consumption of cigarettes, cigarillos, cigars or pipe:		
_____		
6) Do you drink Alcohol?	☐	☐
If so, what is your normal weekly consumption of alcohol (please state also whether beer, wine or spirits):		
_____		
7) Have you ever taken drugs other than those prescribed by a doctor?	☐	☐
If so, please give details (date, duration, type of drugs) on the back signed by yourself.		
8) 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) on the back signed by yourself.		

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☐ ☐

9) 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) on the back signed by yourself.

I hereby declare that the foregoing statements and answers are full, complete and true. I agree that they shall be the basis of the issuance of assurance for me under the Group Policy, and the ……. Assurance Company shall not be liable for any claim on account of illness, injury, or death, the cause of which was known prior to approval of my request for assurance and withheld or concealed in the above statements.

I authorize any physician, nurse, hospital official or employee to disclose to the ……. Assurance Company any and all information regarding my medical history.

_____	_____	_____
Place	Date	Signature of Investors/Participant