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Window Takaful Operations

Health Questionnaire for Group Family Takaful Plan

Applicable only for MCB-AH VPS Account Holders

Existing MCB-AH Investors ☐ Yes, Master Relationship No. _____ ☐ No

Name of Company: MCB-Arif Habib Savings & Investment Ltd. Group Policy No. _____

Name of Investor _____ Date of Birth: _____

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

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

Height _____ Weight _____ Gain or Loss past Year: _____

Beneficiary/Nominee Name (Beneficiary/Nominee can only be a blood relation): _____

Beneficiary/Nominee CNIC: _____ Relationship with Investor: _____

Personal Physician (Name and Address): _____

Takaful sum covered/Total invested value: _____

	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 had 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:

_____

_____

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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.

_____

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 coverage for me under the Group Family Takaful Plan, and Adamjee Life Assurance Co Ltd - Window Takaful Operations 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 coverage and withheld or concealed in the above statements.

I authorize any physician, nurse, hospital official or employee to disclose to Adamjee Life Assurance Co. Ltd – Window Takaful Operations any and all information regarding my medical history.

_____	_____	_____
Place	Date	Signature of Investor

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COVID QUESTIONNAIRE FORM

PLEASE ANSWER FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEGDE.

1 - Do you currently have or have you had any of the following symptoms in the past 14 days?

- ☐ Fever
- ☐ Sore throat
- ☐ Dry cough
- ☐ Myalgia/arthralgia (generalized body ache/ pain in joint areas)
- ☐ Headache
- ☐ Shortness of breath
- ☐ Fatigue
- ☐ Dysgeusia (distortion of the sense of taste)
- ☐ Anosmia (loss of the sense of smell)

If yes, please provide further details i.e. dates, duration, treatment, results of investigations (if any), name and address of treating doctor/clinic/hospital.

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2 - Have you been tested for Covid-19?

Yes **No**

If Yes: Date of the test: ……
(Please share the last COVID-19 PCR report if COVID positive within 3 months)

Result of the test:

- □ **Covid-19 positive**
- □ **Covid-19 negative**

Have you made a complete recovery with no sequelae? **Yes** **No**

3- Within the past 14 days have you had any contact with someone confirmed as infected with the virus?

Yes **No**

4- Have you been issued any notice or directive to self-quarantine or stay home (excluding as part of altered employment arrangement)?

Yes **No**

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5- Are you currently residing outside your usual country of residence or have you returned to your usual country of residence within the last 4 weeks?

Yes **No**

If yes, please provide information: Country / City / Departure Date / Arrived Date / Planned return date.

……
……

6- In the next three months, do you intend to travel outside your usual country of residence?

Yes **No**

If yes, please provide information: Country / City / Date of Travel / Intended Duration

……
……

Documents checklist:

- **COVID - 19 Questionnaire attached:** **YES** **NO**
- **Investor CNIC copy attached:** **YES** **NO**
- **Beneficiary/Nominee CNIC copy attached:** **YES** **NO**

I hereby declare that the foregoing statements and answers are true and that no fact has been withheld. I agree that they shall constitute part of my application for group family takaful coverage. I understand and accept that failure to disclose a fact or giving false information may invalidate the contract or may result in non-payment of a claim.

Date: …….. Place: ……

_____

Signature of Investor