

### 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 No. is mandatory for Employee, Spouse, Parents and Children (for above 18 year of age)**

"Pre-Existing Medical Condition" means any sickness, disease or injury or any symptom related to such sickness, disease or injury which has been diagnosed, treated or is under treatment or has been known, even if no medical advice or treatment was sought, prior to applying for insurance.

Name of Employee:  Gender:  Employee ID   
In CAPITAL letters First / Middle / Given Name(s) Male/Female (If any)

Employer Name:  Designation:  Joining Date:  Marital Status

Home Address:  Marriage Date

Subsidiary/ Location (if any)  CNIC No:  Date of Birth

Tel: (Res)  Cell  Tel (Buss)

Please list Family Members (spouse, son, daughter, mother and father) to be covered: *Attach additional sheets if necessary*  
*In case of addition of spouse due to marriage, Please attach the copy of Nikahnama.*

NAME Please write in CAPITAL letters	Relationship with You	Date of Birth (dd/mm/yyyy)	Height (ft./in)	Weight (lbs)	CNIC No. (Mandatory)
1.					
2.					
3.					
4.					
5.					
6.					
7.					

1) Are / have you or any member of your family (spouse/children/parents) currently or at any time prior to applying for insurance:	<b>YES</b>	<b>NO</b>
a. Suffered from any medical condition / disease / illness or injury? .....	<input type="checkbox"/>	<input type="checkbox"/>
b. Aware of any medical condition / disease / illness or injury (even if no doctor was consulted)? .....	<input type="checkbox"/>	<input type="checkbox"/>
c. Received diagnosis from a Doctor / Hakeem or Homeopath (even if no treatment was provided)? .....	<input type="checkbox"/>	<input type="checkbox"/>
d. Taking or been advised to take any medication for more than 7 continuous days? .....	<input type="checkbox"/>	<input type="checkbox"/>
e. Suffered from any physical or mental disability? .....	<input type="checkbox"/>	<input type="checkbox"/>
2) Do you or any member of your family smoke any form of tobacco or consume alcohol? If yes, how much? .....	<input type="checkbox"/>	<input type="checkbox"/>
3) Are you and all members of your family (listed above) in good health? .....	<input type="checkbox"/>	<input type="checkbox"/>
4) a. Is your spouse (or yourself, if you are a female) pregnant? If yes, how many months? .....	<input type="checkbox"/>	<input type="checkbox"/>
b. Date on which last delivery was conducted. ....		

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

<p><b>DECLARATION:</b> 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 Allianz EFU Health Insurance Limited are the basis for the Group Health Insurance applied for. I hereby authorize any hospital, physician or surgeon who has attended to me or my family members to furnish to Allianz EFU with any and all information that they may require concerning our medical history and/or examinations.</p>	<p><b>TO BE FILLED BY THE EMPLOYER</b></p> <p>Please specify the plan for this employee</p> <p><input type="checkbox"/> Executive <input type="checkbox"/> Deluxe <input type="checkbox"/> Standard</p> <p><input type="checkbox"/> Value <input type="checkbox"/> Basic</p> <p>Other _____</p> <p>Coverage Effective Date: _____</p>	
	<p>Signature of Employee for Self &amp; on behalf of family members being covered _____</p>	<p>Signature &amp; Stamp of the Employer _____</p>
	<p>Date _____</p>	