

Family Enrolment Questionnaire Form (FEQ)

Name of Employee:
In CAPITAL Letters First / Middle / Given Names(s) Last Name

Father/Husband Name:

Employer Name: Work Telephone:

Home Address:

Designation: Date of Joining:

Home Telephone: NIC #

Family Details

Please list Family Members (spouse, son, daughter, mother and father) to be covered: *Attach additional sheets if necessary.*

S. No.	Name <small>Please write in CAPITAL Letters</small>	Relationship with you	Sex (M/F)	Date of Birth (dd/mm/yyyy)
1		SELF		
2				
3				
4				
5				
6				
7				
8				
9				
10				

<p>DECLARATION: 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 style="text-align: center; margin: 0;">TO BE FILLED BY THE EMPLOYER</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 <input type="checkbox"/> Other _____</p> <p>Date of Coverage: _____</p>
<p>_____ Signature of Employee for Self & on behalf of family members being covered</p>	<p>_____ Date</p>
<p>_____ Signature & Stamp of the Employer</p>	