

Family Enrolment Questionnaire Form (FEQ)

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

Father/Husband Name: Grade / BPS

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.*
In case of addition of spouse due to marriage, Please attach the copy of Nikahnama.

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

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.

TO BE FILLED BY THE EMPLOYER

Please specify the plan for this employee

- Executive Deluxe Standard
 Value Basic Other _____

Date of Coverage: _____

 Signature of Employee for Self & on behalf of family members being covered

 Date

 Signature & Stamp of the Employer

Please fill either in English OR in Urdu only