TRUST Islami Life Insurance PLC

PP Size Photograph of the Insured

Insurance Application Form

Declaration of Good Health (D.G.H)

(To be filled by Employees of Organization)

Name of Proposed Insured: .....

Father's Name:..... Mother's Name:.....

Date of Birth : (dd/mm/yyyy)...../...../..... Designation.....Mobile No:.....

Nominee Name:.....

Mailing Address :.....

Sex: Male ☐ Female ☐ Height (cm)..... Weight (kg).....NID:.....email:.....

	Yes	No
1. Are you now in good Health & entirely free from any physical impairment or deformities?	☐	☐
2. Have you ever had or been advised to have a blood test for AIDS or an AIDS related conditions or have you ever been Refused as a blood donor?	☐	☐
3. Has any proposal for insurance/application for revival of a policy on your life been declined/postponed/withdrawn or accepted with extra premium or any restrictive clause or on terms other than proposal ?	☐	☐
4. **For Females only** : Since the date of your applying for Life insurance with PILIL : a. Are you pregnant or not ?	☐	☐
5. Have you any history of Cancer, leukemia Hodgkin's disease, lymphoma, brain or spinal tumors including benign brain or spinal growths ?	☐	☐
6. Do you have history of heart disease, including heart attack, angina, cardiomyopathy (a condition of the heart muscle) or heart valve disorder, Bypass surgery **(last 1 yr)**	☐	☐
7. Do you have history of Stroke, brain hemorrhage, paralysis, transient ischemic attack (mini stroke)or any permanent brain injury ?	☐	☐
8. Do you have history of Mental illness that has required psychiatric or hospital assessment or treatment, schizophrenia, bi-polar disorder, manic depression ?	☐	☐
9. Disease or disorders of the liver or pancreas, including cirrhosis or pancreatitis?	☐	☐

DECLARATION

The forgoing statements and answers are full, complete and true & I have not concealed any information's .I agree that they shall be the basis of insurance for me and the Trust Islami Life Insurance PLC shall not be liable for any claim of Death ,disability, hospitalization & Outpatient the cause of which was known prior to approval of my request for assurance and withheld or concealed in the above statements. I hereby authorize any physician , nurse , hospital official or employee to disclose to the Trust Islami Life Insurance PLC any information it requests about me with reference to any treatments, examinations , advice or hospitalization.

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Signature of Proposed Insured / Applicant Date (DD/MM/YYYY)

Witnessed by : ....

Name of Organization Official Signature & Seal of the Official