askari general insurance company

askari health
The health insurance program

DECLARATION FORM 'A' (DFA)
(Health Insurance Declaration)

askari health – 3rd floor, Mall Road, Rawalpindi. - Ph: 051-9272425-6 051-9028101-2, Fax: 051-9028219

FOR EMPLOYEES & THEIR DEPENDENTS TO BE COVERED AGAINST GROUP MEDICAL INSURANCE POLICY

FOR OFFICE USE ONLY

Sr. No._____ Credit Letter / Folio No._____ Category_____

Policy No._____ Valid From_____ Valid Through_____ Date of Inclusion_____

TO BE FILLED IN BY THE EMPLOYEE

Organization Name_____

Employee Name_____ S/o, D/o, W/o_____

Designation_____ Place of Posting_____ Category_____

Date of Birth_____ Sex (M / F)____ Marital Status_____ CNIC No._____

Blood Group_____ Emergency Phone No._____ Date of Joining_____

Residential Address_____

_____

DEPENDENTS DETAIL

NOTE:
= N.I.C. Number is mandatory for individuals above 18 years.
= Issuance of Credit Letter / Health Card is subject to completion of the following columns.
= Please fill the form in capital letters.

SR #	NAME	RELATION	D.O.B.	C.N.I.C. NO.
01				
02				
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04				
05				
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12				
13				
14				
15				

askari general insurance company limited
3rd floor, AWT plaza, Mall Road, Rawalpindi.
Ph: 051-9028101-2, 9272425-6, Fax: 0519028219

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Please provide the following information regarding yourself and your dependents to be insured under the "*askari health*" group medical policy. If someone is suffering from the given diseases, please write the disease and sufferer's name in below given box and provide detailed disease summary. Additional details maybe sought afterwards.

I. DREAD DISEASE

☐ Myocardial Infarction (Heart Attack) Yes/ No ☐ Previous By-Pass Surgery / CABG
☐ Malignancy (Cancer) ☐ Cerebrovascular-Accident (CVA. Stroke) ☐ Aids (HIV Infection)
☐ Chronic Renal Disease / Kidney Failure ☐ Major Burns (Yes/ No)

II. CHRONIC DISEASE

☐ Diabetes Mellitus (Y/N) ☐ Hypertension (High Blood Pressure) ☐ Epilepsy (Seizures
☐ Ischemic Heart Disease (IHD, Angina) ☐ Tuberculosis (TB) ☐ Psychiatric Disorders

ANY OTHER AILMENT

☐ Accident / Trauma ☐ Eye Problem (e.g., Cataract, Glaucoma) Hernia / Fistula ☐ ENT Problem (e.g., ☐ DNS, Tonsillitis
☐ Gynecological Disease (e.g., Bleeding Problem, Fibroid Uterus

Name of Disease	Name of Sufferer

(FOR WIFE AND MARRIED FEMALE EMPLOYEES)

Pregnant (Yes / No) (If 'Yes' Then): Pregnant Since _____ Months

IV. SMOKING / ANY OTHER ADDICTION

Smoker (Yes / No)_____ Other Addictions_____

V. CONGENITAL DISEASES

The employee or any of his / her dependent suffering from any congenital (by birth) disease, defect of disability)
Name of Defect / Disability and Sufferer _____

VI. MISCELLANEOUS

The employee is requested to disclose / declare any other disease or disability he / she or any of the dependent is or was suffering from not mentioned / disclosed in this form, earlier. It is requested that a true state of health / disease should be disclosed in the form, not with holding any fact to the best of his / her knowledge. Please note also that any claim before the period of coverage is Liable to be rejected unless fully disclosed and mutually agreed before coverage.

Is any of your dependent entitled for medical benefit/ health insurance from any other source?

NAME_____

Declaration:

I,_____S/o. D/o, w/o_____do, hereby, solemnly affirm that all the information provided by me is true and correct to the best of my knowledge. Nothing has been concealed in the declaration. There exists no claim at this time of coverage.

C.N.I.C. NO. | | | | | | | | | | | | | | | |

NAME & SIGNATURE
OF THE EMPLOYEE

Date_____

SIGNATURE & STAMP
OF THE EMPLOYER

(For Office use only)