ASKARI GENERAL INSURANCE COMPANY LIMITED
HEALTH
3rd floor AWT Plaza , The Mall , Rawalpindi.
Phone - 051-9028101-2
Fax- 051-9272424.
www.agico.com.pk
ISO 9001:2008
CERTIFIED

DECLARATION FORM 'A' (DFA)

(Health Insurance Declaration)

FOR EMPLOYEES AND THEIR DEPENDANTS TO BE COVERED AGAINST GROUP MEDICAL INSURANCE POLICY

FOR OFFICE USE ONLY

Sr. No._____ 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

- *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/No.	Name	Relation	Date of Birth	CNIC Number
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

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.

□ Myocardial Infarction (Heart Attack) □ Previous By-Pass Surgery / CABG □ Malignancy (Cancer) □Cerebrovascular-Accident (CVA/Stroke) □ Aids (HIV Infection) □Chronic Renal Failure □Major Burns

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

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

SMOKING/ANY OTHER ADDICTION
Smoker (Yes / No) _____Other Addictions_____

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_____

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 Li able to be rejected unless fully disclosed and mutually agreed before coverage.
Any Other AILMENT_____

Name of the Disease	*Name of the Sufferer*	*Relationship with the Employee*

(FOR WIFE AND MARRIED FEMALE EMPLOYEES)
Pregnant (Yes / No) _____ (If "Yes" Then) Pregnant Since _____Months

Is any of your dependent entitled for medical benefit/ health insurance from any other source? Yes/No
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.
CNIC NO._____

_____ DATE_____ _____

NAME & SIGNATURE OF THE EMPLOYEE

SIGNATURE AND STAMP OF THE EMPLOYER