STATE LIFE
INSURANCE CORPORATION OF PAKISTAN

HEALTH INSURANCE APPLICATION FORM

Policy Number: (to be filled by State Life)	**Proposal Date:**
Name of Applicant (in block letters) *:	
(S/O, D/O, W/O, H/O) *:	
Applicant CNIC No*.:	
Occupation:	
Postal Address*:	**City*:**
Contact No.*:	**Alternate Contact No.:**
Email Address:	

FAMILY MEMBERS TO BE COVERED (please use additional sheets, if necessary).

S. NO	NAME	CNIC NO.	RELATIONSHIP	DATE OF BIRTH*	GENDER*
1*	*As Above*	*As Above*	SELF		
2					
3					
4					
5					
6					

(Please read the following questions carefully and answer each question by ticking the appropriate box)

1) Have you or any of your family members (Spouse/Children/Parents):
   a. Suffering from any medical condition/disease/illness/injury? If yes, details ______________________ Yes ☐ No ☐
   b. Receiving any diagnosis from a Doctor/Hakeem or Homeopath (even if no treatment is provided)? Yes ☐ No ☐
   c. Are any of the members listed above suffering/suffered from any physical deformity? Yes ☐ No ☐
   d. Do any of the members listed above have/had any congenital abnormality/birth defect? Yes ☐ No ☐
   e. Do any of the members listed above suffer or have suffered from any mental, psychiatric or nervous disorders? Yes ☐ No ☐

2) Do you or any member of your family smoke or consume alcohol? ______________________ Yes ☐ No ☐
3) Are you or your spouse pregnant? If yes, how many months? ______________________ Yes ☐ No ☐
4) Are you and all members of your family (listed above) in good health? Yes ☐ No ☐

PLEASE PROVIDE DETAIL(S) FOR THE QUESTION(S) 1(a) to 1(e) TICKED" YES".

NAME OF THE PERSON WITH PRE-EXISTING CONDITION	NATURE OF ILLNESS	NAME OF THE HOSPITAL/ATTENDING PHYSICIAN	PRESENT STATUS ON MEDICINE/SURGERY AWAITED/RECOVERED)

Plan Name: ______________	Plan Category/Coverage: ______________	Premium Amount (Office Use): ______________

FOLLOWING DOCUMENTS MUST BE ATTACHED WITH THE FORM	
[ ] CNIC / B-Form Of Members	**[ ] Declaration Form (For Specific Products)**

DECLARATION

I, on behalf of any included dependents and myself apply for health insurance cover and agree to be bound by the policy document. I declare that, to the best of my knowledge and belief the answers and information I have given are true, accurate and complete and that I have not withheld any information in regard to this application that ought to be disclosed to State Life Insurance Corporation of Pakistan. I understand that if any of the information provided by me is incorrect or incomplete, State Life Insurance Corporation of Pakistan will be entitled to refuse to pay my benefits and/or cancel my policy.

میں اپنے اور زیر کفالت افراد کی جانب سے ہیلتھ انشورنس کے حصول کے لیے درخواست دیتا ہوں اور پالیسی دستاویز کی شرائط کا پابند رہونگا۔ میں تصدیق کرتا ہوں کہ، میرے علم کے مطابق میں نے جو معلومات اور کوائف فراہم کیے ہیں وہ درست اور مکمل ہیں۔اس درخواست کے سلسلے میں ایسی کوئی معلومات خفیہ نہیں رکھی گئی ہیں جو کہ اسٹیٹ لائف انشورنس کارپوریشن آف پاکستان کو ظاہر کرنا ضروری ہوں۔ اگر فراہم کردہ معلومات غلط یا نامکمل ہوں، تو اسٹیٹ لائف انشورنس کارپوریشن آف پاکستان میرے فوائد کی ادائیگی سے انکار کرنے اور/یا میری پالیسی منسوخ کرنے کا حقدار ہوگا۔

____
Signature of Applicant

FOR OFFICE USE ONLY

Name of Zone: ______________ -	
(Marketing Agent Information)	
Code:	Full Name:
CNIC: ______________	Contact No :

Email: Corporate.health.kz@statelife.com.pk or Toll Free: 0800-07007