Effective Date
Plan
Folio No.

Atlas Insurance

Atlas Insurance Ltd.

3-Bank Square, Shahrah-e-Quaid-e-Azam, Lahore.
PABX: +92(42) 3732-0542/3, 3732-2271 & 73, Fax: +92 (42) 3723-4742
E-mail: atlascare@atlasinsurance.com.pk, Website: www.atlasinsurance.com.pk

AtlasCare Health Insurance

Declaration Form

Name of the employee: Sex: ☐ Male ☐ Female

Father's/ Husband's Name: Martial Status ☐ Single ☐ Married ☐ Divorced

Date of Birth:

N.I.C / Passport No: Policy holder's Name:

Home Address:

Telephone No:

Occupation: Designation:

Company Name (Employer):

Business Address:

Telephone No:

Dependents

SR. No.	Name of the Dependent	D.O.B	NIC/Passport No.	Sex M/F	Relation with the Employee

1. a) Have you or any of your dependent consulted a medical practitioner or specialist within the last 12 months? ☐ Yes ☐ No.

   b) Have you or any of your dependent been referred to a hospital, specialist or admitted to a hospital, nursing home or other medical facility within the last 5 years ? ☐ Yes ☐ No.

2. a) Have you or any of your dependent ever suffered from high blood pressure, heart disease, diabetes, shortness of breath, tumors or growth, jaundice, fits or convulsions, pain in chest, paralysis, lung or kidney disorders, nervous or psychiatric disorder? ☐ Yes ☐ No.

   b) Are there any other illness, disabilities or defects present that may require treatment and have not already been disclosed or mentioned above ? ☐ Yes ☐ No.

3. Are you or any of your dependent currently taking medication of any kind ? ☐ Yes ☐ No.

4. For female only
   a) Are you pregnant? if yes, please state duration .... ☐ Yes ☐ No.

   b) Have you ever had any gynecological, obstetrical, or breast disease? ☐ Yes ☐ No.

If 'Yes' to any of the question 1-4, please provide nature and duration of the medical condition, Dates of consultations, type of treatment and likelihood of the need for further treatment. Use separate sheet of paper. if required. Please mention Name of the suffer and relation with the employee.

DECLARATION

I hereby certify that all answers to questions appearing on this form are true and complete to the best of my knowledge belief. I am also aware that subject to the terms of acceptance of my coverage, this declaration / authorization together with the master policy document shall form the contract between policyholder and insurer. I authorize any doctor, hospital, clinic or medical service provider, insurance company, or any other institution, or any person, who has any record or information about me and/or any of my dependents to provide Atlas Insurance Company Limited with the complete information including copies of their records with reference to any sickness, accident, disability any treatment, examination, medical investigation, advice or hospitalization. Photocopy of this authorization shall be valid as the original.

Dated at ____________ this ____________ day of ____________ 20______ Signature of Employee ____________________

Employee will complete and sign the form.

I / We hereby certify that all answers to questions appearing on this form are true and complete to the best of my / our knowledge and belief.
I / We agree that above statement / declaration shall form the basis for the coverage of Insurance.

Dated at ____________ this ____________ day of ____________ 20______

Seal of Employer ____________________ **Signature of Employer** ____________________

For Office use only

Additional requirement :			
	❑ Statment from insured person		
	❑ Statment from physician		
	❑ Medical reports		
	❑ Other		

Risk Factor :

Underwriting Assessment :

Underwriting Decision :