ANNEXURE

Health Questionnaire form

This questionnaire is to be filled by the employee. Please use Ball Point. Use of correction fluid or overwriting will render the form invalid and fresh form will be required. Any alteration must be signed by the employee.

Name of Employee: (In Block Letters) ____________________
Son of / daughter of / spouse of____________________
Employer's Name & Address: ____________________

____

Employee Code No.: __________ To be enrolled under category: __________ ____
Date of birth: __________ Height (ft) __________ Weight (lbs) __________
Employee's Designation __________ Description of Duties: __________
Employee's N.I.C. No. __________

Residential Address: __________ __________ Phone No. __________

FAMILY MEMBERS TO BE COVERED: (PLEASE USE ADDITIONAL SHEET IF NECESSARY).

NAME (USE BLOCK LETTERS)	RELATIONSHIP	DATE OF BIRTH	HEIGHT (FT)	WEIGHT (LBS)	OCCUPATION

(Please read the following questions very carefully and answer each question by ticking in the appropriate boxes. If the answer to any question is "YES", please give full details disclosing all material facts & attach copies of reports investigations as they can influence the assessment and acceptance of the application. If you are in any doubt as to whether any fact is material, you should disclose it, as failure to do so may invalidate a future claim.)

(a) Please provide the name and address of your usual Family Physician(s), If any Name of Doctor:__________		(b) If you (or any family member to be insured) have seen any Attending Physician in connection with your physical or mental health within the last 3 years, please provide his/her name and address and reasons for consultation.	☐ Yes ☐ No
(c) Has any of your immediate family members (mother, father, brother and sister) suffered from heart disease, stroke, hypertension, cancer, kidney or diabetes or hereditary/familial disorder before age of 65?	☐ Yes ☐ No	(d) Do you smoke tobacco or drink alcohol? If so, please state daily consumption of tobacco and or weekly intake of alcohol?	☐ Yes ☐ No
(e) Have you (or any family member to be insured) had			
(i) Heart disease including structural defects and murmurs?	☐ Yes ☐ No	ii) High blood pressure or disease of the blood vessels or circulatory system including varicose veins?	☐ Yes ☐ No
(iii) Stroke or disorder of the brain?	☐ Yes ☐ No	(iv) Diabetes, thyroid disorders or gout?	☐ Yes ☐ No
(v) Anemia or disorder of the blood?	☐ Yes ☐ No	(vi) Kidney disease including disease of the bladder and any disorder of the reproductive system such as endometriosis, fibroids, ovarian cysts?	☐ Yes ☐ No
(vii) Cancer, tumour or abnormal growth?	☐ Yes ☐ No	(viii) Respiratory disease or lung disorder?	☐ Yes ☐ No
(ix) Mental or nervous disorder?	☐ Yes ☐ No	(x) Paralysis, tremor, numbness, double vision, giddiness or disorder of the central nervous system?	☐ Yes ☐ No
(xi) Eye, ear, nose or other throat disorder?	☐ Yes ☐ No	(xii) Back pain including any muscular problem or disorder of the bones or joints?	☐ Yes ☐ No

ANNEXURE

Health Questionnaire form – Continued

(xiii) Digestive problems or disorder of the gall bladder or pancreas?	☐ Yes ☐ No	(xiv) Liver disease including hepatitis B & C carrier status?	☐ Yes ☐ No
(xv) Skin disease	☐ Yes ☐ No		
(f) Have you (or any family member to be insured) had or been advised by a physician to have medical treatment or surgery for any other physical ailment not already described in Questionnaire?	☐ Yes ☐ No	(g) Have you (or any family member to be insured) ever been tested positive for HIV/AIDs or any other sexually transmitted disease, or are you awaiting the results of such a test?	☐ Yes ☐ No
(h) Have you (or any family member to be insured) undergone any type of special investigation such as CT Scan, MRI, or surgical operation within the last 3 years?	☐ Yes ☐ No	(i) Are you (or any family member to be insured) currently taking any treatment or medication or awaiting medical investigations, laboratory test, treatment or surgery?	☐ Yes ☐ No
(j) Have you, your spouse or any of your children suffered or suffering from any congenital disease (disease present since birth)? And are under treatment.	☐ Yes ☐ No	(k) Have you (or any family member to be insured) been absent from work due to medical reasons for a continuous period of a week or more during the last 3 years?	☐ Yes ☐ No
(l) Are you/or your spouse pregnant now?	☐ Yes ☐ No		

PLEASE GIVE DETAIL OF ANY "YES" ANSWERS TO THE ABOVE QUESTIONS

QUESTION NUMBER	NAME	TYPE OF DISORDER	DATE	DURATION	RESULT	NAME & ADDRESS OF DOCTOR / HOSPITAL

DECLARATION AND AUTHORIZATOIN

I hereby declare that what has been stated above is true and complete and the best of my knowledge and belief. I have not withheld any material information and that it is understood and agreed that this declaration the application of my employer to the Crescent Star Insurance Limited.. are the basis for the Group Hospitalization Insurance cover applied for, and that any non-disclosure or misrepresentation of facts will make my/our insurance cover void since inception.

I hereby authorize any hospital, physician, or surgeon who has or may attended to me or my family to furnish to the Crescent Star Insurance Limited with any information they may require concerning my/our medical history or examinations.

_________________ (Signature of Employer) with Official Seal

_____________________ (Signature of Employee) for self & on behalf of dependants

Signed at _______________ date __________

FOR THE USE OF CRESCENT STAR INSURANCE LIMITED.

Approved:

(1) Hospitalization Standard Substandard Extra Morbidity ________________________

(2) Dread Disease Standard Substandard Extra Morbidity ________________________

If substandard, due to following reasons: ____

1) ____

2) ____

3) ____

4) ____

Any other remarks ____

____________________ Underwritten by

________________ Date