

Individual Enrollment Form-Group Insurance

IGI Life Insurance Limited

IMPORTANT NOTICE

To expedite the approval of applied for insurance coverage, do not leave any blanks, unanswered questions, medical reports, dates and/or signatures, wherever applicable. To expedite processing any maintenance request on insured Employees, indicate under Part C, the individual Employee's Cert. No. per IGI Life records/billings/enrollment lists IGI Life reserves the right to request medical evidence of insurability and to accept or reject any application as per its underwriting standards.

For IGI Life use only:

IGI Life Cert No. _____
 Group No. _____
 Ind. Eff. Date & _____
 any u/w Comments: _____
 Date & u/w's initial: _____
 Other Comments: _____

Part A - To be Completed by Employee if requesting Insurance on self:

1. Employee's Name:

(Last Name) (Middle Initial) (First Name)

2. Employer's Name:

3. Address: City: Country:

4. Date of Birth: Day: Month: Year: 5. CNIC No.: 6. Nationality:

7. Height: Ft / cm. 8. Weight: Lbs / Kg. 9. Sex: 10. Marital Status:

11. Do you fly other than as a passenger on an aircraft in regularly scheduled common carrier for passenger service?
Yes No12. Are you involved in any dangerous sports such as professional sports, mountaineering, diving, parachuting, racing, horse riding?
Yes No13. Do you smoke cigarettes or use any other form of tobacco? If yes, please indicate number per day
Yes No14. Have you consulted a physician for any illness during the past five years or are currently under any form of medical treatment or intend to seek medical advice, treatment or have any medical test performed?
Yes No15. Has any application for insurance on your life been declined, postponed, or modified, or do you know of any impairment in your health or physical condition?
Yes No16. Have you ever been treated for or told you had or intend to seek medical advice, treatment or medical test performed for heart disease, high blood pressure, diabetes or sugar in your urine, kidney disease, lung disease, cancer, disorder of the back or joints, nervous disorder or disorder of the stomach or abdominal organs?
Yes No17. If female, are you pregnant? (If yes, state duration)
Yes No

18. AIDS (Acquired Immune Deficiency Syndrome) Question-Describe in detail any affirmative answers:

Have you received medical advice, or treatment, in connection with AIDS or an AIDS related condition or a sexually transmitted disease? Have you been told you had AIDS or AIDS complex? Have you had or been told you have positive blood test for antibodies to the AIDS virus? or Do you have any of the following which are unexplained: fatigue, weight loss, diarrhoea, enlarged lymph nodes or unusual skin lesions?

19. If answer is "Yes" to any of the above question 14 to 18, please give full particulars below (If reason for consultation is check-up, please indicate exact reason, date performed, type of exam performed and attach any available results). Use separate sheet if necessary and attach copies of hospital discharge reports and up to date medical report from treating physician.

Question No.	Details of Condition	Duration of Condition	Date of Treatment	Complete Recovery Month Year	Name & Address of Physician or Hospital

20. Beneficiaries for death benefits only (please also complete Part B on the reverse if requesting medical insurance for your dependents)

(Beneficiary Name & Address)	(Percentage of Proceeds)	(Relationship to Employee)

If nothing specified under Percentage of Proceeds above then equal split between/among Beneficiaries. If any Beneficiary listed above dies before me, the interests of such Beneficiary shall, unless otherwise provided above, accrue to the Surviving Beneficiaries or Beneficiary or if none to my estate. I reserve the right to change any Beneficiary named above.

"I hereby understand and agree that no action at law can be brought by me or by my dependents, beneficiaries or by any third party in respect to any claim under the Group Policy except with the written consent of the Group Policyholder".

Employee's Signature
(Please Complete Reverse Side)

Date

FORM MUST BE COMPLETED, DATED & SIGNED TO BE VALID

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Part B - To be Completed by Employee if requesting medical insurance for dependents:

1. Who are your eligible dependents (Spouse & dependent children only)?
(If more space needed, complete additional form)

Full Name To Employee	Relationship	Date of Birth Day Mo. Yr.	Height (Ft/cm)	Weight (lbs/kg)	For IGI Life use only Department's Effective Date

2. Name and address of any dependent if living, outside your country of work residence for more than six months in a year?
3. Have any of your dependents named above: Smoke cigarettes or use any other form of tobacco? If yes, please indicate number per day
4. Have any of your dependents named above:
 a) Consulted a physician for any illness during the past five years or is currently under any form of medical treatment or intend to seek medical advice, treatment or have any medical test performed?
 b) has any application for insurance on their life been declined, postponed, or modified, or do you know of any impairment in their health or physical condition?
 c) been treated for or told they had or intend to seek medical advice, treatment or medical test performed for heart disease, high blood pressure, diabetes or sugar in their urine, kidney disease, lung disease, cancer, disorder of the back or joints, nervous disorder or disorder of the stomach or abdominal organs?
Yes No
5. To be answered by married male employees only. Is your spouse pregnant? (If yes duration.....)
Yes No
6. AIDS (Acquired Immune deficiency Syndrome) Question-Describe in detail any affirmative answers:
 Have any of your dependents named above received medical advice, or treatment, in connection with AIDS or AIDS related condition or a sexually transmitted disease? Have any of your dependents named above been told they had AIDS or AIDS complex? Have any of your dependents named above had or been told they had a positive blood test for antibodies to the AIDS virus? or Do any of your dependents named above have any of the following which are unexplained: fatigue, weight loss, diarrhoea, enlarged lymph nodes or unusual skin lesions?
Yes No
7. If answer is "Yes" to any of above question 4 to 6, please give full particulars below (If reason for consultation is check-up, please indicate exact reason, date performed, type of exam performed and attach any available results). Use separate sheet if necessary and attach copies of hospital discharge reports and the most upto date medical report from treating physician.

Name of Department	Question No.	Details of Condition	Duration of Condition	Date of Treatment	Complete Recovery Month Year	Name & Address of Physician or Hospital

Part C - To be Completed by Employer/Policyholder

1. Employee's Name:

(Last Name) (Middle Initial) (First Name)

2. Employer's/Policyholder's Name: 3. Employment Date: Day Month: Year:

4. Group Policy No. 5. Class/Subgroup No. 6. Employee's Cert No. (per IGI Life records)

7. Occupation: Monthly Salary: (provide if volume is a multiple of salary) 8. Amount:

9. From a health standpoint, do you know of any reason why the employee or any of his dependents should not be insured or Yes No has the employee been absent from work because of sickness or injury during the past six months?

If answer is "Yes", please give full details and dates: _____

10. Requested Date of Coverage: _____

Part D - Employee's and Employer's/Policyholder's Signature

I hereby certify that all answers to questions appearing on both sides of this form are complete and true to my knowledge. I hereby authorize any doctor, hospital, clinic or medical provider, an insurance company or any other company, institution or any other person who has any record or information about me and/or any of my dependents to provide IGI Life insurance Limited with the complete information, including copies of their records with reference to any sickness or accident, any treatment, examination, advice or hospitalization. Any photocopy of this authorization shall be valid as the original copy.

policyholder's signature & stamp

Date

Employee's signature