SHAHEEN INSURANCE COMPANY LIMITED
Joint Venture Of Shaheen Foundation-PAF, Hollard Insurance and FCSC
H.No.46,Khayaban-e-Suharwardy, Islamabad P.O Box No: 44000
UAN: (92-51)111-765-111 Fax.No: 92-51-2829515

Individual/Family Data Form

For Individual and their dependents to be covered against Individual/Family Medical Insurance Policy

Individual Name		S/o, D/o, W/o	
Date of Birth & Age		Gender	
Designation		State Company Name Or whether Self Employed	
National ID card No			
Contact Person(In case of emergency)		Emergency Tel No	
		Mobile Number	
Present Residential (Mailing) Address		Res Tel No	
		Mobile Number	

DEPENDENTS(If Any) –Applicable in case of Family Insurance

S No.	Name	Relation	Age	DOB	NIC No.
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					

If Pregnant then kindly state since _____ Month

Which of the following (If any) is the employee or the dependent suffering from?

	Name of the sufferer
Myocardial Infarction (heart attack)	
Previous By-pass (Date)	
Cancer	
Cerebra-vascular accident (Stroke)	
Kidney Disease	
AIDS	
Hepatitis B	
Hepatitis C	
Major Burns	
Diabetes	
Hypertension (Blood Pressure)	
Angina	
TB	
Epilepsy	
Psychiatric Disorder	
Any Congenital Disease (by birth)	

It is requested that a true state of health / disease should be disclosed in the form, not withholding any fact to the best of his / her knowledge. This will help us in your claim reimbursement & processing.

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

_____

Name and Signature of Individual

NOTE: The following should accompany the filled out form

1. Photocopy of the NIC card of the Individual and the dependent
2. Two photographs of the Individual and the covered dependent
3. Attach `B-Form` for dependents under 18 years of age