EAST WEST LIFE
ASSURANCE COMPANY LIMITED

Formerly The Metropolitan Life Assurance Co. of Pakistan Ltd.

Head Office: 310-EFU House, 3rd Floor, M.A. Jinnah Road, Karachi-74000,
Tel: 2311662/5, 2310726, 2310904, Fax: 2311667,
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Affix Two N.I.C. Size Photographs of the Employee ONLY

EMPLOYEE ENROLMENT FORM (EEF)

- This questionnaire is to be filled by the employee.
- While filling out this form, please follow the instruction carefully and write in block letters only.
- Please note that use of correction fluid/blanco or overwriting will render the form invalid and a fresh form will be required. Any alteration must be signed by the employee.
- Alongwith this form, please attach readable CNIC photocopies of the employee and all the family members to be insured, whose age is more than 18 years.

SECTION A : PERSONAL INFORMATION

Name of Employee _____ S/O, D/O, W/O _____

Home Address _____ Phone _____ Employee Code _____

Sex ☐ Male ☐ Female Marital Status ☐ Married ☐ Single Height (Fr.) _____ Weight (Lbs.) _____ Blood Group _____

Date of Birth _____ Date of Appointment _____ Date of Confirmation _____

Designation _____ Description of Duties _____

C.N.I.C. No. _____ Employer's Name and Address _____

SECTION B : DETAIL OF FAMILY MEMBERS

Please provide the details of all of your immediate family members. In the last column, indicate whether you wish for the particular family member to be covered under our hospitalization policy or not. Use additional sheets, if necessary. If additional sheets have been used, please tick this box

NAME (Use Block Letters)	RELATIONSHIP WITH EMPLOYEE	BIRTH DATE	HEIGHT (FT.)	WEIGHT (Lbs.)	C.N.I.C. #	COVERAGE TO BE PROVIDED
						Yes ☐ No ☐
						Yes ☐ No ☐
						Yes ☐ No ☐
						Yes ☐ No ☐
						Yes ☐ No ☐
						Yes ☐ No ☐
						Yes ☐ No ☐

Please read the following questions very carefully and answer each question ticking boxes where appropriate. If the answer to any question is "YES" ,please provide full details disclosing all material facts and attach copies of reports / investigation. If any reports/investigation or any other document is being provided, please tick this box

1. Please provide the name, address and phone number of your usual Family Physician(s). if any.

Name of Doctor _____ Address _____ Phone _____

2. Have you or any member of your family (spouse, children, parents, brothers, sisters) ever suffered, had any indication of, or expired due to any of the following diseases.a) Any Form of Cancer b) Heart Disease / Disorder c) Diabetes Mellitus d) Stroke / Paralysis e) Kidney Disease / Disorder f) Abnormal Blood Pressure g) Blindness h) Hereditary/Familial Disease/Disorder. — Yes ☐ No ☐

3. Do you smoke tobacco or consume alcohol? If yes, mention quantity. — Yes ☐ No ☐

4. Have you or any member of your family to be insured had or been advised by a doctor to have medical treatment, procedure, investigation or surgery for any of the following:

a) Heart diseases, related structural defects or murmurs?	Yes ☐ No ☐	h) Kidney disease or disorder of the genito-urinary organs, diseaseof the bladder and any disorder of the reproductive system, such as: prostatitis, albumen, endometritis, fibroids, pelvic infection, any cyst?	Yes ☐ No ☐
b) High blood pressure or diseases of the blood vessels or circulatory system?	Yes ☐ No ☐	i) Disease or disorder of digestive system, gall bladder, pancrease disorder, such as: ulcer, hernia, piles or fistula?	Yes ☐ No ☐
c) Diabetes, thyroid disorders or gout?	Yes ☐ No ☐	j) Anemia, arthritis, rheumatism, tumor, goiter, tuberculosis, cancer, abnormal growth or any disorder of the blood?	Yes ☐ No ☐
d) Back pain, musculer problems or bone/joint disorders?	Yes ☐ No ☐	k) Liver disease including hepatitis B carrier status?	Yes ☐ No ☐
e) Any kinds of skin diseases or disorders?	Yes ☐ No ☐	l) Fever, malaria, dengus, diarrhoea or any other infectious or parasitic disease?	Yes ☐ No ☐
f) Stroke or disorder of brain, mental or nervous system, such as: paralysis, tremor, numbness, double vision, giddiness, convulsion, nervous breakdown. spinal disease?	Yes ☐ No ☐	m) Any physical deformily, any impairment of vision or hearing?	Yes ☐ No ☐
g) Respiratory disease or disorder of the nose, throat, lungs, chest, such as: pleurisy, asthama, palpitations, shortness of breath, bronchitis, or sinusitis?	Yes ☐ No ☐	n) Any illness, injury or impairment not already mentioned above?	Yes ☐ No ☐

5. 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 waiting for the results of such a test?	Yes ☐ No ☐
6. Have you (or any family member to be insured) undergone any type of X-ray examination, laboratory test, special investigation or surgical operation within the last 3 years?	Yes ☐ No ☐
7. 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 ☐
8. Have you, your spouse or any of your children suffered, suffering or are under treatment for any congenital disease (disease present since birth)? If "Yes" please state nature of disease:	Yes ☐ No ☐
9. Have you (or any family member to be insured) been absent form work due to medical reasons for a continuous period of a week or more during the last 3 years?	Yes ☐ No ☐
10. This question is in regards to female employee or wife of male employee only : Are you (female employee) or your wife pregnant at the present time? If "Yes" ,please state expected date of delivery and detail of complication, if any, so far. _____ _____	Yes ☐ No ☐

PLEASE GIVE THE DETAIL OF ANY "YES" ANSWER TO THE ABOVE QUESTIONS IN THE FOLLOWING FORM.

In the first column please provide the question number, which you are elaborating in the pertinent row. Use additional sheets, if necessary. If additional sheets have been used, please tick this box ☐

Q.#	NAME OF PATIENT	TYPE OF DISORDER	DATE	DURATION	RESULT	NAME AND ADDRESS OF DOCTOR/HOSPITAL

SECTION D : DECLARATION

I hereby declare that whatever is stated above is true and correct to the best of my knowledge. I also understand that this declaration together with the application of my employer to East West Life Assurance Company Limited the basis of Group Hospitalization Insurance applied for. I hereby authorize any hospital, physician or surgeon who has attended me or my family to furnish to East West Life Assurance Company Limited with any information they may require concerning our medical history or examinations in connection with their insurance.

_____
Signature of the Employee for self & on behalf of members of the family being covered.

_____
Signature of the Employer & Seal

Date _____

SPECIMEN SIGNATURE OF EMPLOYEE FOR EWL HOSPITALIZATION CARD

Please sign in the three boxes shown below for printing on the EWL Hospitalization Card. Kindly make sure that the signature does not fall outside of the boxes shown below.

Signature of Employee	Signature of Employee	Signature of Employee

FOR OFFICE USE ONLY

1. Policy No._____ 2. Family Code _____ 3. Channel Reference: _____
4. Underwriting Decision _____

☐ Accepted ☐ Rejected ☐ Accepted with Additional Premium Rs._____

Requirements _____

_____

Underwritten by: _____

Name _____

Signature _____

Doctor's Remarks_____

_____

_____

Doctor's Name_____

Doctor's Signature_____