DAWOOD FAMILY TAKAFUL LIMITED

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PERSONAL STATEMENT FORM

WARNING : You have to disclose information in this form truly and faithfully regarding all the facts which you know or ought to know otherwise the Certificate & all its related Endorsements issued hereunder considered null and void.

A : DETAILS OF PARTICIPANT

Certificate No.

Full Name of Participant

B : QUESTIONS CONCERNING PARTICIPANT

(if the answer to any of the below is 'YES', please complete Part C on the next page)

	YES / NO
1. Present Occupation & daily duties ________________	
2. Height __________ cm Weight _____________ kg	
3. Have you applied for any Family Takaful / life insurance that has been declined postponed, modified or is now pending?	
4. Are you now engaged or do you contemplate to engage in any hazardous sports or hobbies?	
5. Are you a member/employee of or do you plan to join any military, or become member of aviation organization?	
6. Have you ever taken or now take alcohol excessively or used narcotic stimulants?	
7. Have you had any illness, injury or consulted any physician or been subjected to X-rays ECG blood tests or other tests or been hospitalized since the application date of this Takaful?	
8. Has any of your immediate family ever suffered from or died from cancer including breast cancer, tuberculosis, diabetes, multiple sclerosis, mental illness or any AIDS related or Hearing diseases or disorders Diseases?	
9. Is your health impaired in any way?	
10. (Female Applicant Only) Are you pregnant? If "Yes" months?	
11. Are you now in Good Health?	
12. Are you now or have you since last declaration remained under any medical complaint, investigation, treatment, supervision or admission?	

____
Signature of Applicant

C : Please Complete This Part (if Part B is "YES")

ILLNESS / SICKNESS		ACCIDENT / INJURIES
1. What illness? Please describe ____________		1. What kind of Accident? Please describe ____________
2. How long old you/insured suffer from that illness? Duration? ____________		2. Date of Accident? ____________
3. Are you currently on medication or talking treatment or any kind?	YES / NO	3. Which part of body was injured? What type of injury? (e.g. Fracture, cut, bruise etc.)
4. Are you now on full time employment? If no why?		4. Are you currently on medication or treatment of any kind after the accident?
5. Have you fully recovered?		5. Have you fully recovered?

HOSPITALIZATION

		YES / NO
1. Please state reason for hospitalization ____________	4. Did you undergo any surgery? If YES, when? ____________ What was the result? ____________	
2. Date admitted ____________ Date discharged ____________		
3. Name of hospital and doctor who treated you? Hospital ____________ Doctor Name ____________	5. Is there any follow up required? If YES, when is the next follow up?	
	6. Are you now on full time employment? If NO, why? ____________	

OTHER INVESTIGATIONS	
1. Please name the examination/test done Date	If any answer to question B (4) to B (9) is YES, Gave details below ____________
2. Reason	____________
3. Result	____________

I the under signed do hereby declare that:-

The statements made here in and in my previous declarations are true and I have not concealed, withheld or reserved any information, affecting the risk of Takaful under this Proposal/Certificate.

From the date of my last Declaration till this day, I have had no illness or injury, nor there has been any change in my personal and family history except as declared above.

And I do hereby agree that:-

This declaration together with all Declarations made or to be made by me in respect of this Proposal/Certificate shall form the basis of the contract between me and DFTL.

If any untrue statement be contained in any of my declarations, all contributions which have been paid on account of Takaful shall be considered property of WAQF fund and certificate shall be absolutely null and void. Any payment made by me in advance and acknowledged by DFTL provisionally shall be treated as deposit involving no liability to DFTL until and unless the DFTL acting upon this declaration shall have adjusted the same as contribution by issuance of a properly stamped receipt during my life time and good health.

I do hereby authorize any Hospital, Laboratory/Physician, Surgeon or any other person who has attended me or may attend in future to give DFTL all knowledge and information which was thereby acquired including the history obtained and diagnosis made.

Witnessed By:

Signature ____________

Name ____________

Designation / CNIC # ____________

Place ____________ *Date* ____________

Usual signature of the Participant:

____

Signed at ____________ Date ____________