IGI Life

Individual Enrollment Form-Group Insurance

IGI Life Insurance Limited

Formerly 'American Life Insurance Company (Pakistan) 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's use only:

IGI Life's 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/Policy holder's Name:

3. Mailing Address: Street: 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. ☐ Yes ☐ No Do you fly other than as a passenger on an aircraft in regularly scheduled common carrier for passenger service?

12. ☐ Yes ☐ No Are you involved in any dangerous sports such as professional sports, mountaineering, diving, parachuting, racing, horse riding?

13. ☐ Yes ☐ No Do you smoke cigarettes or use any other form of tobacco? If yes, please indicate number per day .....

14. ☐ Yes ☐ No 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?

15. ☐ Yes ☐ No 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?

16. ☐ Yes ☐ No 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?

17. ☐ Yes ☐ No If female, are you pregnant? (If yes, state duration .....)

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

☐ Yes ☐ No 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)
(Beneficiary Name & Address)	(Percentage of Proceeds)	(Relationship to Employee)
(Beneficiary Name & Address)	(Percentage of Proceeds)	(Relationship to Employee)
(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

Global purpose of MetLife Inc.

FORM MUST BE COMPLETED, DATED & SIGNED TO BE VALID

IMPORTANT NOTICE

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For IGI Life's use only:

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

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	Relationship To Employee	Date of Birth Day Mo. Yr.	Height (Ft/cm)	Weight (lbs/kg)	For IGI Life's 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:
   - ☐ Yes ☐ No 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?
   - ☐ Yes ☐ No 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?
   - ☐ Yes ☐ No 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 hack or joints, nervous disorder or disorder of the stomach or abdominal organs?

5. ☐ Yes ☐ No To be answered by married male employees only. Is your spouse pregnant? (If yes duration.....)

6. AIDS (Acquired Immune deficiency Syndrome) Question-Describe in detail any affirmative answers:
   ☐ Yes ☐ No 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?

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's records)

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

9. ☐ Yes ☐ No From a health standpoint, do you know of any reason why the employee or any of his dependents should not be insured or 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** *Formerly 'American Life Insurance Company (Pakistan) 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

Complaints in Respect of Insurance Policy

If you have any complaint or grievance against the Insurance Company, Broker, Agent, Surveyor or Bank Representative in respect of your insurance policy, you may file your complaint with the following offices:

1. **Federal Insurance Ombudsman**
   2nd Floor, Pakistan Red Crescent Society, Annexe Building, Plot # 197/5, Dr. Daud Pota Road, Karachi.
   Tel: (021) 99207761-62 Website: www.fio.gov.pk

2. **Official Coordinator, Small Disputes Resolution Committee – Islamabad**
   The Management Executive, Insurance Division, 3rd Floor, NIC Building, 63 Jinnah Avenue, Blue Area, Islamabad.
   Tel: (051) 9207091 to 94 - Ext: 439 E-mail: complaints@secp.gov.pk

3. **Official Coordinator, Small Disputes Resolution Committee – Karachi**
   The Deputy Director, Specialized Companies Division, 5th Floor, State Life Building No. 2, Wallace Road, Off I.I. Chundrigar Road, Karachi.
   Tel: (021) 32414204 E-mail: complaints@secp.gov.pk

4. **Official Coordinator, Small Disputes Resolution Committee – Lahore**
   The Deputy Registrar of Companies, Company Registration Office, 3rd & 4th Floor, Associate House, 7 - Egerton Road, Lahore
   Tel: (042) 99204962 to 66 - Ext: 28 E-mail: complaints@secp.gov.pk

بیمہ پالیسی کے متعلق شکایات

اگر آپ کو اپنی بیمہ پالیسی کے متعلق انشورنس کمپنی، بروکر، ایجنٹ، سروئیر یا بینک نمائندے کے خلاف کوئی شکایت ہو تو درج ذیل دفاتر میں رابطہ کر سکتے ہیں:۔

وفاقی انشورنس محتسب،
سیکنڈ فلور، پاکستان ریڈ کریسنٹ سوسائٹی، انیکسی بلڈنگ،
پلاٹ نمبر 197/5، ڈاکٹر داؤد پوتا روڈ، کراچی
فون: 021-99207761-62
www.fio.gov.pk

دفتری رابطہ کار (اسلام آباد)
اسمال ڈسپیوٹس ریزولوشن کمیٹی
سیکورٹیز اینڈ ایکسچینج کمیشن آف پاکستان
تھرڈ فلور، این آئی سی ایل بلڈنگ، اسلام آباد
فون: 4-051-9207091 ایکسٹینشن 439
ای میل: complaints@secp.gov.pk

دفتری رابطہ کار (لاہور)
اسمال ڈسپیوٹس ریزولوشن کمیٹی
سیکورٹیز اینڈ ایکسچینج کمیشن آف پاکستان
ایسوسی ایٹ ہاؤس، 3rd فلور، 07، ایجرٹن روڈ، لاہور۔
فون: 042-99204962-66 (Ext 28)
ای میل: complaints@secp.gov.pk

دفتری رابطہ کار (کراچی)
اسمال ڈسپیوٹس ریزولوشن کمیٹی
سیکورٹیز اینڈ ایکسچینج کمیشن آف پاکستان
5th فلور، اسٹیٹ لائف بلڈنگ 02، ولاس روڈ،
آف آئی آئی چندریگر روڈ، کراچی۔
فون: 021-32414204
ای میل: complaints@secp.gov.pk