BML INSURANCE

INDIVIDUAL TERM ASSURANCE PROPOSAL FORM
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Family History

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Have you previously made any life proposal with Allied? ؟ ڇڻ ناعيش ءَخَمِءَش عَمِڤ ڤُڈَہْ ںَںَںِشْھُ؟	Yes ☐ ؟	No ☐ ںَںْش

Family history ؟ ڤَمِڤُڈَ ںَمْڈُںَھُ	Age if living ؟ ھَڈُںَ	State of health ؟ ںِہْبِ ںَڭَمُھُ	Age at death ؟ ںِڭَمُھِ ھَڈُںَ	Cause of death ؟ ںِڭَمُھِ ںَھَھَھْ
Father ؟ ھَہْڤَ				
Mother ؟ ںَںْمَ				
Brothers ؟ ءَہْھَںَںْ ڤِںِںَںْ				
Sisters ؟ ءَہْھَںَںْ ءَںْںَںْ				

Personal History

ءِںْشُہْءَں ںَںَڭُ ڤَںَڭُڈَ ںَہْںَ ںَںَںْدُںَھُ

Height: _____ cm ؟ ءِںْںَںَڭُ ںَمْ
Weight: _____ kg ؟ ھَںَڭَںَش ںَمْ
How many cigarettes do you smoke daily? _____ ؟ ڤَںْشُڤَھُڈَ ءِںْھُءِڤَںْدَھُ ںَںَںَھْڤُھُ ںَںَںَھْڤُںَںَ، ڤَںْڤُھَںَڈُ ںِھَڤَہْ ںِںَڤِ ںَںَڭَھْ ھَںْںَںْںَںَھْڤُںَںْھُ؟

Name and address(Clinic/Hospital) of your usual medical attendant: _____
؟ ڤَہْڈُںَںْش ڤَںَڤُڈَ ءَںْںَھَڈُڈَ ںَڭَڤِ ںَںِںِںْ/ ںَںْھُڤَڭُھُ

Has been attendant for _____ years ؟ ڈَھِڤُڈَ ڤَںْشُںْڤُھُ ءَںْںَھَڈُںَ ڤَںَڤُںَھُڤُھِ ںَہْڤَڭُھُ
Date of last visit: _____ ؟ ھَںْشُڈُ ڤَںْش ءَںْںَھَڈُںَش ڤَںَڤُںِ ھُڤِںْ

Reason for last visit: _____
؟ ھَںْشُڈُ ڤَںْش ءَںْںَھَڈُںَش ڤَںَڤُںِ ںَھَھَھْ

a. In addition to the visit mentioned above have you consulted any other medical practitioner (please give name) during past five years? ں. ڈَھِڤُڈَ ڤَںْشُںْڤُھُ ءَںْںَھَڈُںَش ءَںْںَھَڈُںَش ھُڤُھُڤُںِںَ ڤَںَڤُڈَ ھَںَںَڈُڈَ ںَہْڈُںَھُڤُھِ ڤَںَڤُںَھُںْھُ؟ (ںَڭَڤُھِ ءَںْءَںَش ءَںَڤِ ںَھَھَھْ ءَڤَںْںَھُ) Yes ☐ ؟ ھَںْش No ☐ ںَںْش

If Yes give full particulars: _____
؟ ھَںَںَںْ ںَڭَڈَ ءِھُںَڈَ ھَڤْںِںْھُ

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b. Have you ever attended hospital for treatment, operation or investigation or had any x-ray? ں. ءَہْڈُھُںْ ءِںَڭَہْڈَھِ ڤَںَڤُںَںَںَڈَش، ھَںْںِڤُھَڤُ ںَڭَڈَش ںَڭَھَھَ ءَںَںْںُ-ںَڭَ ءَہْ ںَڭَڈَش ںَںْھُڤَھُڤُںَش ڤَںَڤُںِںْھُ؟ Yes ☐ ؟ ھَںْش No ☐ ںَںْش

If Yes give full particulars: _____
؟ ھَںَںَںْ ںَڭَڈَ ءِھُںَڈَ ھَڤْںِںْھُ

c. Have you ever suffered from any of the following?
ں. ھِںِڤَڈَ ڈِڤَںْشَڭَ ءَہْڈُھُںْ ںَڈَہْ ھَںَہْڈَڈَ ںَںَہْڈَھُش ڤَںِںَڤَءَڤِںْشُںْھُ؟

1. Bronchitis, asthma or any other complaint of the lungs or respiratory system. Yes ☐ ؟ ھَںْش No ☐ ںَںْش
1. ھَںَںْشُںَءِڤِںْ، ںَڭَںَںِڤُںْش ںَڭَھَ ںَڭَڭَ ںِںَڭُڈَ ءَہْڈُھُںْ ھَہْںَہْ؟

If Yes give full particulars: _____
؟ ھَںَںَںْ ںَڭَڈَ ءِھُںَڈَ ھَڤْںِںْھُ

2. a. Any form of heart or circulatory trouble or disorder of the stomach or bowels hemorrhage, fainting or fits? Yes ☐ No ☐
b. Are you a beta Thalassaemia carrier?

ހ. ހިއުގެ ބަންދުވުމުގެ ބަންދުވުން ބަންދުވުން ބަންދުވުން ބަންދުވުން ،ބ. ،ބ. ،ބ. ،ب. 2.

ب. ،ب. ،ب. ،

11. Stroke High or Low blood pressure? Yes ☐ No ☐

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e. Has any Insurance company ever requested any additional premium or postponed or declined a proposal for life assurance on your life? Yes ☐ No ☐

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Beneficiaries (If any)

ھۮۯۭۺۯ ۺۯۏۯ ڳڕۭۺۭ ۋڕ ۇڕۭ ڄۭۺۭ ۋڕۭ ڳڕۯۯۯ

Name: ـــــــ