DATA COLLECTION FORM FOR PROPOSAL OF HEALTH INSURANCE/HEALTH COVERAGE OF JUDICIAL STAFF OF KP

PERSONAL INFORMATION

Name:_______________________________ Father's Name: ______________________________

CNIC No:_____________________________ Date of Birth (AGE):__________________________

Complete Address:____

____ Marital Status:____________________

Residence Phone Number:______________________ Cell Phone Number:_________________

WORK

Registration No (if any):________________________Designation: ________________________

Address:____

Office Phone Number: ______________________

FAMILY INFORMATION (enter information of dependent parents & children)

Spouse Name:_____________________________ Date of Birth_________________________

CNIC No: _________________________________ Employed: ____________________________

Mother's Name:______________________________ Date of Birth_________________________

CNIC No: __________________________________ Employed: _________________________

Fathers Name:______________________________ Date of Birth_________________________

CNIC No: __________________________________ Employed: _________________________

Child 1 Name:_____________________________ Gender:_____________ DOB_______________

CNIC No: __________________________________ Employed: _________________________

Child 2 Name:_____________________________ Gender:_____________ DOB_______________

CNIC No: __________________________________ Employed: _________________________

Child 3 Name:_____________________________ Gender:_____________ DOB_______________

CNIC No: __________________________________ Employed: _________________________

Child 4 Name:_____________________________ Gender:_____________ DOB_______________

CNIC No: __________________________________ Employed: ______________________________

Child 5 Name:_____________________________ Gender:_____________ DOB_______________

CNIC No: __________________________________ Employed: ______________________________

Child 6 Name:_____________________________ Gender:_____________ DOB_______________

CNIC No: __________________________________ Employed: ______________________________

Child 7 Name:____________________________ Gender:_____________ DOB_______________

CNIC No: _________________________________ Employed: ______________________________

Child 8 Name:____________________________ Gender:_____________ DOB_______________

CNIC No: _________________________________ Employed: _________________________

Have you or any of your family members have the following problems (If yes mention the name of members and indicate the disease), Use extra sheets if required.

Cardiac

Diabetes

Paralysis

Hepatitis B

Hepatitis C

Kidney Disease

Cancer

Any other fatal diseases

Please note that this is a data collection form for preparation of proposal and doesn't constitute any obligation on the part of Govt or Insurance Company.

(Note) In case of any Confusion please contact to welfare Officer SDJ PHC

0333-9338366