DAWOOD FAIMILY TAKAFUL LIMITED

COVID - 19 DECLARATION FORM

Proposal/Certificate Number: | | / | | | | | | | / | | | | | | |

Full Name:

CNIC | | | | | | - | | | | | | | | - | |

Date of Birth | D | D | - | M | M | - | Y | Y | Y | Y |

PLEASE ANSWER FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEGDE:

1. Do you currently have or have you had any of the following **symptoms** in the past 14 days?

☐ Fever ☐ Headache ☐ Myalgia/arthralgia (generalized body ache/ pain in joint areas)
☐ Sore throat ☐ Shortness of breath ☐ Dysgeusia (distortion of the sense of taste)
☐ Dry cough ☐ Fatigue ☐ Anosmia (loss of the sense of smell)

If yes, please provide further details i.e. dates, duration, treatment, results of investigations (if any), name and address of treating doctor/clinic/hospital.

_____

_____

_____

2. Have you been tested for ***Covid-19***? ☐ YES ☐ NO

If YES: Date of the test: | D | D | - | M | M | - | Y | Y | Y | Y |

Result of the test:

☐ Covid-19 positive ☐ Covid-19 negative

Have you made a complete recovery with no sequelae? ☐ YES ☐ NO

3. Within the past 14 days have you had any contact with someone confirmed as infected with the virus? ☐ YES ☐ NO

4. Have you been issued any notice or directive to self-quarantine or stay home (excluding as part of altered employment arrangement)? ☐ YES ☐ NO

5. Are you currently residing outside your usual country of residence or have you returned to your usual country of residence within the last 4 weeks? ☐ YES ☐ NO

If yes, please provide information:

Country: _____ City: _____

Departure Date: _____ Arrived Date: _____

Planned Return Date: _____

6. In the next three months, do you intend to travel outside your usual country of residence? ☐ YES ☐ NO

If yes, please provide information:

Country: _____ City: _____

Date of Travel: _____ Intended Duration: _____

Declaration:

I hereby declare that the foregoing statements and answers are true and that no fact has been withheld. I agree that they shall constitute part of my application for life assurance / takaful cover. I understand and accept that failure to disclose a fact or giving false information may invalidate the contract or may result in non-payment of a claim.

Date: | D | D | - | M | M | - | Y | Y | Y | Y |

_____ Place

_____ Signature of person Proposed/Covered: