STATE LIFE
INSURANCE CORPORATION OF PAKISTAN
Registered & Supervised by the Securities & Exchange Commission of Pakistan
KARACHI SOUTHERN ZONE

Telephone : 99217001-19
U.A.N. : 111-555-888
Telegrams : BEEMAZINDAGI
E-mail : phskszn@statelife.com.pk

STATE LIFE BUILDING NO. 2, P.O. BOX 4599, WALLACE ROAD, KARACHI-74000

DECLARATION IN RESPECT OF PROPOSAL / POLICY NO. _____

Name _____ National Identity Card No. _____

Date of Birth _____ Place of Birth _____ Mobile No. _____

CNIC _____ Expiry _____ Issuance Date _____ Mother Name _____

1. What illness of injury have you had since the date of your first declaration ? Give details-date, duration etc. _____
2. What deaths have there been in your family (parents, brothers, sisters, spouse or children) since the date of your first declaration ? Give age at death, cause of death and duration of illness. _____
3. Have you ever made a proposal for insurance on your life which has not been accepted at ordinary rates or under the plan and term proposed ? _____
4. Are you now in good health ? _____

FOR FEMALES

5. Are you pregnant at present ? _____

APPLICATION TO CHILD PROTECTION PLAN

6. Is your child now in good health ? _____

I, the undersigned hereby declare that:-

1. The statements made herein and in my previous declarations are true and I have not concealed. reserved any information effecting the risk of assurance under this Proposal / Policy.
2. From the date of my first declaration till this day, I have had no illness or injury no there has been any change in my personal and family history except as declared.

And I do hereby agree that:-

1. This declaration together with all declaration made or to be made by me in respect of his Proposal / Policy shall form the basis of the contract between me and the State Life Insurance Corporation of Pakistan.
2. If any untrue statement be contained in any of my declarations, all moneys which shall have been paid on account of said insurance shall be forfeited to the State Life and the assurance shall be absolutely null and void.
3. Any paymnet made by me in advance and acknowledged by the State Life Provisionally shall be treated as deposit involving no liability to the State Life Unit and unless the State Life acting upon this declaration shall have adjusted the same as premium by issuance of a properly stamped receipt during my life time and good health.

I, hereby authorise any hospital, physician surgeon.or any other person who has attended me or may attend in future to give the State Life Insurance Corporation of Pakistan, all knowledge and information which was hereby acquired including the history obtained and the diagnosis made.

Signature of Witness _____

Name _____

Father's Name _____

N.I.C. No. / Code No. _____

Address _____

_____
Usual Signature of the Proposer / Life Insured

Place _____ Date _____

Endorsement

1) Lapsed / Revived Policies

In consideration of Revival of policy It _____ I undertake that I will not ask for the poilcy loan or surrender value under this policy before passing Two. Complete years i.e. (24 Months) from the date of Revival.

2) Auto Paid up Reinstated Policies

In consideration of reinstatement of Auto Paid up Policy # _____ I undertake that only 70% of policy loan will be allowed / offered to me after passing one complete year i.e. 12 Months from the date of reinstatement and no surrender value will be allowed to me before completing two years i.e. (24 Months) from reinstatement date of policy.

Date: _____

_____
Signature of the Policyholder

PHS - 18
30P/01-24

STATE LIFE INSURANCE CORPORATION OF PAKISTAN
PHS DIVISION-PRINCIPAL OFFICE-KARACHI
1st Floor, State Life Building No. 9, Dr. Zia-ud-Din Ahmad Road, Karachi.
Ph: 021-99202838-9920873-9920878, Fax: 021-99202826, Email: dgmphs@statelife.com.pk

CONFIDENTIAL REPORT BY SALES MANAGER/AREA MANAGER IN LIEU OF FMR ON THE LIFE OR ILLITERATE PROPOSED

NAME OF LIFE PROPOSED _____ PROPOSAL NO. _____
SUM ASSURED _____ Table / Term: _____

1.	Is the life proposed related to you?	
2	If "NO" how long have you know the life proposed?	

Answer the following based on your Professional Experience and Personal Observations:

3.	Have you noticed any visible scars, marks, abnormalities, signs of physical / physiological impairments?	
4.	Does the life proposed appear healthy & fit in all respects? If found otherwise state details?	
5.	Do the measurements & weight as mentioned in proposal, seem consistent with individual's appearance.	
6.	Do you think that proposed has ample financial standing and social repute in the community.	
7.	Is there any indication of existence of "Moral Hazard" in this case?	
8.	The thumb impression on the is in-fact of the life proposed as claimed?	
9.	Do you recommend the proposed for medical check-up (FMR)? If "YES" specify details.	
10.	Any Additional observations requiring further scrutiny.	

Declaration by Sales Manager:

I do hereby declare that the above proposal is canvassed by me and that I am satisfied with the identity of the life proposed. I also declare that the forgoing statements are correct and true to the best of my belief and knowledge.

I have verified to the best of my knowledge, that the identify of prospect is not ficlitious. It is my recommendation that the above proposal be exempted from FMR and accepted, based on the information provided by the proposed and verified by me as above. In the event of a claim, if dis-information is proved I agree to bear "full responsibility" for any losses incurred in the Corporation.

Dated: _____ Signature: _____

Place: _____ Stamp: _____

Countersigning by Area Manger/ Sector Head

I hereby certify to the authority of the above report and recommend the above case for approval. I have read the "Declaration" above and agreed with the terms and conditions declared. I undersigned that the signing below I agree to share the responsibility as stated in the last "para" of the Declaration.

Dated: _____ Signature: _____

Place: _____ Stamp: _____

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AMENDMENT TO PROPOSAL / POLICY

Proposal / Policy No. _____

I _____, holder of NIC No. _____ hereby request that my above life insurance proposal / policy dated _____ 20____ be amended as follows:

This is to certify that I am in as good health as when I signed the Personal Statement of Health which constituted a part of my proposal for insurance to STATE LIFE INSURANCE CORPORATION OF PAKISTAN, and that since the date of such statement there has been no change in my occupation or family record, nor have I had any illness or disease, nor have I consulted or been examined by any phyisician, and I have not applied for new Insurance, change in plan or reinstatement which was declined, postponed, withdrawn or modified in kind or rate and I understand that the issuance or delivery to me of any policy issued on said application and declaration is conditional upon the truth fullness of the above statements. I also understand that any untrue statements would render the life insurance contract null and void and no claim will be payable thereunder.

Signed at _____ this _____ day of _____ 20____

Witness:
Signatures _____

Name _____

Code NIC No. _____

Address: _____

_____
Signature of life proposed

_____
Signature of life proposer
(if other than life proposed)

INSURANCE CORPORATION OF PAKISTAN

Proposal No.

Serial No.

KNOW YOUR CUSTOMER FORM
INDIVIDUAL LIFE

Annexure A

Important

Please use capital letters and black ink.
Tick the appropriate box to indicate your choice.

Proposed Life Insured's / Policy holder's full name (IN CAPITAL LETTERS)			Prefix
First Name	Second Name	Last Name	

Computerized National ID Card No.

CNIC - Expiry Date / /

Father's / Husband's Name:

Nationality: ☐ Pakistani ☐ United States of America ☐ Other_____(Please specify)

Resident: ☐ Pakistan ☐ Other_____(Please specify)

Passport No._____ Date of Expiry_____ if nonresident Pakistani, please Complete separate CRS - Certification form.

Foreign Account Tax Compliance Act (USA) - Information for United States Person only.

Are you a United States person?

Generally a United States person is:	Yes	No
A citizen or resident of the United States.	☐	☐
A United States partnership / Corporation.	☐	☐
An estate that constitutes a United States estate	☐	☐
Place of birth is in United States.	☐	☐
Any trust if: A court within the United States is able to exercise primary supervision over the administration of the trust and one or more United States person(s) have the authority to control all substantial decisions of the trust.	☐	☐

If yes, complete CRS and W-9, form seprately.

Are you a politically exposed person (PEP) or a family member / close relative or a associate of PEP?	☐ Yes	☐ No
Did you spend a minimum of 183 days in US during the last 3 year period? If so, expiry of overseas card:	☐ Yes	☐ No
Have you given power of attorney / mandate to any person? If so, overseas contact No:	☐ Yes	☐ No
Have you renounced your Foreign citizenship/residency?	☐ Yes	☐ No

If so, details:	
IRS Form (W-BEN / W-9) submitted	☐ Yes ☐ No

Note: In case of third party insurance contract, a separate Know your customer (KYC) form is also required to be submitted by life proposer.

DECLARATION

This additional questionnaire is the party of proposal form under reference.

Singed at _____ **Date:** _____

_____

Signature of life proposed with thumb impression

_____

Signature with thumb impression of Proposer (If other than life proposed)

Witness's signature: _____
(With rubber stamp)
Name: _____
Father's name: _____
CNIC No: _____
Address: _____

LTI or RTI (Male or Female)

Policy (Account) Number:

Family Name: Given Name:

Identity Card/Passport No.: Date of Birth (DD/MM/YYYY):

Residential address:

Country: Postal Code:

Mailing address, if different from residential address:

Country: Postal Code:

Contact Number: (Cell) (O) (H)

Email Address:

CRS Declaration of Tax Residency	Please note you can tick more than one
I am a tax resident in Pakistan*.	
I am a tax resident of other jurisdictions*.	

* Please provide below the list of all the countries in which you are a resident for tax purposes and the associated Tax Identification Number ("TIN").

Country of Tax Residence	TIN	If TIN is not available please select and explain reason below^

^ Reason why TIN is not available.

Reason A – The country does not issue TINs to its residents

Reason B – Unable to obtain TIN or equivalent number. Please tell us why in the box below:

Reason C – TIN is not required. (Note: To be selected only if the domestic law of the relevant jurisdiction does not require the collection of the TIN issued by such jurisdiction).

I understand that the information supplied by me is covered by the full provisions of the terms and conditions governing the Policyholder/account holder's relationship with State Life Insurance Corporation of Pakistan setting out how State Life Insurance Corporation of Pakistan may use and share the information supplied by me.

I acknowledge that the information contained in this form and information regarding the Policyholder/account holder and any Reportable Account(s) may be provided to the tax authorities of the country/jurisdiction in which this account(s) is/are maintained and exchanged with tax authorities of another country/jurisdiction or countries/jurisdictions in which the Policyholder/account holder may be tax resident pursuant to intergovernmental agreements to exchange financial account information.

I certify that I am the Policyholder/account holder (or am authorized to sign for the Policyholder/account holder) of

all the policy (ies)/account(s) to which this form relates.

I declare that all statements made in this declaration are, to the best of my knowledge and belief, correct and complete.

I undertake to advise State Life Insurance Corporation of Pakistan within 90 days of any change in circumstances which affects the tax residency status of the individual identified in Part 1 of this form or causes the information contained herein to become incorrect or incomplete, and to provide *State Life Insurance Corporation of Pakistan* with a suitably updated self-certification and Declaration within 90 days of such change in circumstances.

Signature:	Date (DD/MM/YYYY):
Note: If you are not the Account Holder, please indicate the capacity in which you are signing the form. If signing under a Power of Attorney, please also attach a certified true copy of the Power of Attorney. Capacity of Signatory: Assignee Trustee Beneficiary Others (please specify):	

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DECLARATION

PROPOSAL NO : _____

I declare that (1) the statement and answer are true, and (2) sum assured is reasonable to my income; and (3) I want to be considered for Insurance under the "NON-DECLINATURE SCHEME" wherein I am not required to disclose my state of health; and (4) I will be covered for accident only, as defined in the policy, for the first two years of the policy and (5) if any statement or answer is untrue the contract of insurance shall be absolutely null and void and all money paid in respect there of shall be forfeited to the Corporation.

I note that the Corporation will not be on risk on my life until the issue of their First Premium Receipt after full consideration of my proposal.

_____
Signature of Witness

_____
SIGNATURE OF PROPOSER & LIFE PROPOSED

Full Name : _____

PLACE _____

DATE _____

Address: _____

_____

If the life proposed has not signed in English the following declaration should be made by an English knowing witness.

I declare that before the life proposed signed this form I read over, translated and explained to him/her the contents of the above form which he/she fully understood.

_____
Signature of Witness

Full Address : _____ Full Name _____

N.B-113
10P/01-13

Proposal/Policy No. _____

Name of Policyholder/Proposer _____

DECLARATION (اقرار نامہ)

I declare that (1) foregoing statements and answers are true in every respect, (2) the sum, insured is reasonable in relation to my income, (3) I have fully understood the terms and conditions of the proposed insurance contract including my obligations and benefits payable to me thereunder, (4) the proposed insurance contract is according to my needs, (5) this statement and declaration together with the statement of health and any statements made to the Medical Examiner shall be the basis of the contract, between the proposed and the State Life Insurance Corporation of Pakistan (hereinafter called the Corporation), and (6) I understand that as per section 79 (3) and (4) of Insurance Ordinance 2000, the Corporation may avoid the contract if the failure to disclose any material information or any misrepresentation of facts, disclosed to the insurer was fraudulent or the misrepresentation was made fraudulently, and corporation has the right to recover damages from me in respect of loss suffered by the corporation, as a result of fraudulent act committed by me or any criminal liability to which I may be subject by reason of fraudulent act by me or to forfeit to the corporation all money paid in respect thereof.

I hereby authorize any hospital(s) physician(s) or any other person(s), who has attended or may in future attend me to give the Corporation all information and *knowledge which was, thereby acquired including the history obtained and diagnosis made I also authorize the Corporation to share information about my proposal as per directives of SECP under the centralized information sharing solution For Life Insurance Industry and Insurance Repository which is for policyholders' protection and sound development of the Life Insurance Industry. I note that the Corporation shall not be on risk on my life until the issue of its First Premium Receipt after full consideration of my proposal.

Apart from the facts mentioned in the above statements and answers and in the personal statement of health, there is no fact or circumstances, which may be material to the underwriting of my proposal.

میں اقرار کرتا/ کرتی ہوں کہ مذکورہ بالا بیانات اور جوابات ہر لحاظ سے درست ہیں (۲) زر بیمہ میری آمدنی کی مناسبت سے ہے۔ (۳) میں نے زیر تجویز بیمہ کے معاہدے کی شرائط وضوابط بشمول اپنی ذمہ داری اور اُس کے تحت مجھے حاصل ہونے والے فوائد کو پوری طرح سمجھ لیا ہے (۴) تجویز کردہ معاہدہ میری ضروریات کے عین مطابق ہے (۵) یہ بیان اور اقرار نامہ بشمول بیان صحت اور میڈیکل ایگزامنر کو دیا گیا بیان اسٹیٹ لائف انشورنس کارپوریشن آف پاکستان اور تجویز کنندہ کے درمیان معاہدے کی بنیاد ہوگا (۶) میں سمجھتا ہوں کہ اگر میں اہم معلومات فراہم کرنے سے قاصر رہا/رہی یا بیان کردہ حقائق دھوکہ دہی اور غلط بیانی پر مبنی ہوئے تو کارپوریشن، انشورنس آرڈیننس ۲۰۰۰ کی شق (۳) ۷۹ اور (۴) کے تحت اِس معاہدے سے انکار کرسکتی ہے اور کارپوریشن کو یہ حق حاصل ہوگا کہ وہ مجھ سے اس نقصان کی قانونی طریقے سے تلافی کرسکے جو کہ میرے دھوکہ دہی کے عمل کی وجہ سے اُٹھانا پڑے یا مجرمانہ ذمہ داری کی وجہ سے وجود میں آئے، اس ضمن میں تمام ادا شدہ رقم بحق کارپوریشن ضبط ہو جائے گی۔

میں ہر اُس اسپتال، معالج یا کوئی اور فرد جس نے میرا علاج کیا ہو یا آئندہ علاج کرے ذریعہ ہذا کو اختیار دیتا/دیتی ہوں کہ کارپوریشن کو عند الطلب میری صحت، تشخیص اور علاج کی مکمل تفصیل فراہم کریں۔ میں کارپوریشن کو اختیار دیتا/دیتی ہوں کہ سیکیورٹیز اینڈ ایکسچینج کمیشن آف پاکستان کی ہدایت کے مطابق میرے پروپوزل کے متعلق معلومات سینٹرل انفارمیشن شیئرنگ سولوشن برائے لائف انشورنس انڈسٹری اور انشورنس ریپوزٹری کو فراہم کرسکے، جو کہ بیمہ داران کے تحفظ اور انشورنس انڈسٹری کی مستحکم ترقی کے لئے ہے۔ میں باور کرتا/ کرتی ہوں کہ میری زندگی کے بیمہ کا تحفظ اُس وقت تک شروع نہیں ہوگا، جب تک کارپوریشن میرے بیمے کی تجویز پر غور وخوض کے بعد منظوری کا فیصلہ نہ کردے اور پہلے پریمیئم کی ادائیگی کی باضابطہ رسید جاری نہ کرے۔

اوپر بیان کردہ حقائق اور صحت کے متعلق بیان صحت کے علاوہ ایسی کوئی کیفیت یا حقیقت بیان کرنے سے باقی نہیں رہی جو اس تجویز بیمہ کی منظوری میں رکاوٹ کا سبب بن سکتی ہو۔

Signed at _____ Date _____
دستخط بمقام — تاریخ

Signature or LTI of Proposer (if other than life poposed)
درخواست گزار کے دستخط یا بائیں ہاتھ کے انگوٹھے کا نشان

Signature or the Life Proposed and both thumb impressio
مجوز کے دستخط اور دونوں ہاتھوں کے انگوٹھے کے نشانات

عورت کے دائیں انگوٹھے کا نشان	مرد کے بائیں انگوٹھے کا نشان

Signature of withness (with rubber stamp) گواہ کے دستخط مع مہر
Name نام
Father's Name والد کا نام
CNIC No. کمپیوٹرائزڈ قومی شناختی کارڈ نمبر

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STATE LIFE
INSURANCE CORPORATION OF PAKISTAN
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KARACHI SOUTHERN ZONE

STATE LIFE

Supplementary Proposal When Proposer is other than Life Proposed

Ref. Attached Proposal No. ..... dated .....

on Life of _____

PARTICULARS OF PROPOSER

1. **Name :**
2. **Father's Name:**
3. **Age :**
4. **Occupation :**
5. **Correspondence Address :**

6. **Details of life insurance policies :-**

Co. & Unit.	Pol. No.	S.A.	Is Policy Infoce ?

7. **Relationship to Life Proposed :**
8. **Insurable Interest in Life Proposed :**

DECLARATION

This supplementary proposal together with the attached proposal dated _____ shall form the basis of the contract between me and the Corporation, and the Declaration to the said attached proposal shall be equally applicable to this Supplementary proposal.

Witness' Signature _____

Name : _____

NIC/Code No. _____

Occupation : _____

Address : _____

_____

_____

Proposer's Signature

Date :

NB-3
10P/2-2012

STATE LIFE
INSURANCE CORPORATION OF PAKISTAN
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KARACHI SOUTHERN ZONE

The Manager
New Business Department,
State Life Insurance Corporation
of Pakistan,
Karachi Southern Zone.

Date : _____

SUB: **DIFFERENCE IN SIGNATURE OF PROPOSER/POLICY HOLDER**

Dear Sir,

I Identify Mr. _____ as Proposer under Proposal No: _____ /Holder of Policy No: _____ and certify that he/she has signed the PROPOSAL FORM - PERSONAL STATEMENT - DECLARATION OF GOOD HEALTH - THREE SPECIMEN SIGNATURES, before me.

OLD SIGNATURES	NEW SIGNATURES
01). _____	_____
02). _____	_____
03). _____	_____

NB-58
20P/08/12

AREA MANAGER'S/SECTOR HEAD'S
SIGNATURE WITH OFFICIAL STAMP

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STATE LIFE
INSURANCE CORPORATION OF PAKISTAN
Registered & Supervised by the
Securities & Exchange Commission of Pakistan
KARACHI SOUTHERN ZONE

NON - RESIDENT LETTER

Date : _____

The Manager
New Business Department,
State Life Insurance Corporation
of Pakistan.
Karachi Southern Zone.

RE: Life Insurance Proposal #.

I have to inform you that I am residing abroad and will remit the premium under the above insurance proposal through my Non-Resident Bank Account in Pakistan From abroad through normal banking channel as required by the State Bank of Pakistan.

_____ _____
Signature of the Witness Signature of the Proposer

Full Name : _____

NIC/Code #: _____

Address: _____

_____

NB-68
10P/01-16

(30)

اسٹیٹ لائف

انشورنس کارپوریشن آف پاکستان

زون

انسپکشن رپورٹ

برائے لازمی نان میڈیکل اسکیم

درخواست بیمہ (پروپوزل) نمبر _____

نام بیمہ کنندہ _____ والد/زوجیت _____

پیشہ _____

رہائشی پتہ _____

شناخت

۱۔شناختی نشان _____

۲۔کیا یہ نشان وہی ہے جو شناختی کارڈ میں درج ہے _____

۳۔شناختی کارڈ نمبر _____ (ب) مقام اجراء _____

۴۔آپ کی اپنے اندازے کے مطابق عمر کیا ہوگی _____

۵۔کیا آپ بیمہ کنندہ کو ذاتی طور پر جانتے ہیں اگر ہاں تو کتنی مدت سے _____

جسامت

۶۔کیا آپ تصدیق کرتے ہیں کہ پروپوزل فارم میں قد، کمر سینہ اور پیٹ کی پیمائش اور وزن ٹھیک درج ہیں _____

۷۔اگر اندراجات درست نہیں تو آپ خود پیمائش اور وزن کر کے درج کریں

وزن _____ قد _____

کمر _____ سینہ (i) _____

پیٹ _____ (ii) _____

صحت

۸۔کیا بیمہ کنندہ بظاہر صحت مند ہے _____

۹۔کیا بیمہ کنندہ زیادہ دبلا پتلا ہے یا زیادہ موٹا ہے

(ب) چہرے سے کسی بیماری کے اثرات دکھائی دیتے ہیں _____

۱۰۔کیا کوئی جسمانی نقص موجود ہے) تفصیل سے بیان کریں)

(بینائی، بہرہ پن، کسی عضو میں نقص وغیرہ) _____

۱۱۔کیا بیمہ کنندہ نے کبھی کوئی آپریشن کروایا یا کسی ہسپتال میں زیر علاج رہا (تفصیلات درج کریں) _____

آمدنی

۱۔ آپ کے خاندان کے مطابق بیمہ کنندہ کی، ماہانہ آمدنی کیا ہے ملازمت یا تجارت سے _____ ماہانہ
دوسرے ذرائع سے _____
کل آمدنی _____

۲۔ کیا آپ کے علم میں کوئی ایسی بات یا معلومات ہیں جس سے
مجوزہ درخواست برائے بیمہ لائف کیلئے منظور کرنا بہتر نہیں _____

۳۔ کیا آپ پورے وثوق کے ساتھ مجوزہ بیمہ کی منظوری
کیلئے سفارش کرتے ہیں۔ _____

میں پورے اعتماد اور یقین کے ساتھ بیان کرتا/کرتی ہوں کہ اوپر دیئے گئے اندراجات میری ذاتی معلو ت کیمطابق درست ہیں اور میں مجوزہ درخواست برائے بیمہ نان میڈیکل اسکیم کے تحت منظور کرنے کی پرزور سفارش کرتا کرتی ہوں

تاریخ _____

دستخط _____

سیلز منیجر/ایریا منیجر

کوڈ نمبر _____

STATE LIFE
Insurance Corporation of Pakistan

_____ZONE

Annexure "B"

S.M/A.M/SECTOR HEAD'S CONFIDENTIALREPORT

PROPOSAL NO. _____ Name: _____ CNIC No. _____

Address: _____

RIDERS: TIR ( ) FIB ( ) SUM ASSURED_____ TSAR _____

1. Life Proposed's name_____
2. Telephone No: Office_____Residence_____
3. (a). Mobile_____ Fax _____ Email _____

a. Details of Declaration of Assets:(Place tick/ in the corresponding box)

Residence: Flat ☐ House ☐ Insured: Yes ☐ No ☐ surance Company_____

Built/purchased in year _____ Inherited: Yes ☐ No ☐ Mortgage/Lien: Yes ☐ No ☐

If 'yes' Mortgage amount: _____ Name of Bank _____

Self-owned ☐ Family owned ☐ Owned since (approx. No. of years)_____

Registered owner _____ Estimated Net worth _____

Additional remarks: _____

Commercial/rental Property: House ☐ Shop ☐ Warehouse ☐ other_____

Self-owned ☐ Family owned ☐ Owned since (approx. No. of years) _____

Mortgage/Lien Yes ☐ No ☐ Registered owner _____

Rental income/month Rs._____ Estimated Net worth Rs._____

Additional remarks: _____

b. Business/es: Factory: Yes ☐ No ☐ If Other (specify) _____

Ownership: Sole ☐ Partnership ☐ Mortgage/Lien Yes ☐ [ ]

If yes Amount_____

Established since_____No. of Employees____ Annual Turnover _____

Registered Yes ☐ No ☐ Registered owner _____NTN _____

Registration with Sales Tax: Yes ☐ No ☐ If Yes then Registration No. _____

Estimated Net worth of business in Rs._____ Business Bank Account: Yes ☐ No ☐

Additional remarks: _____

Vehicles:

(1) Make _____ Year_____ Market Value Rs. _____

(2) Make _____ Year_____ Market Value Rs: _____

Insured by (company) _____ No. of years owned: _____

Name of registered owner (V.1) _____ (V.2) _____

Agricultural Machinery: Tractors ____ Trucks _____ Trolley _____ Other Machinery _____

Estimated Net worth Rs.____ ____ Additional (specify details) _____

_____ _____

C- Investment Portfolio: Stocks ☐ Bonds ☐ Certificates ☐ Other (specify) _____

Government Guaranteed Yes ☐ No ☐ Ownership: Registered ☐ Bearer ☐

Estimated/Actual Net worth (list individually): _____

_____ _____

Additional remarks: _____ _____

Agriculture Landholding Size (i)____ ____acres, Location: _____ Deh/Tapo/Tehsil/Distt _____

Type: Nehri/Barani_____

Size(ii) _____acres, Location: _____ Type: Nehri/Barani _____

Size (iii) _____acres, Location: _____Type: Nehri/Barani _____

Estimated Total (a + b + c) _____

Self-owned: Rs._____ Spouse owned: Rs._____

6. Earning members in the family residing in the same house.

Name	Relationship	Occupation	Yearly Income	Policy No. & Name of Insurer (if insured)

7. Life Proposed's Passport No. _____
Date and Place of Issue _____

8. Countries travelled

Country	Duration of Stay	Year	Purpose of Visit

9. State of Health and General Appearance _____

_____

10. Estimated Annual Income _____

11. Is life proposed known to you, if yes since how long _____

12. Remarks regarding social, financial Standing, Income and general reputation in the community_____

_____

Declaration by Reporting Officer:

I do hereby declare that the above proposal is canvassed by me and that I am satisfied with the identity of the life proposed. I also declare that the foregoing statements are correct and true to the best of my knowledge and belief.

- I have personally visited and verified the properties (Business/Residence)/ vehicles/Agricultural Land/Investment portfolio etc. as mentioned above in Column No. 3 and I am also satisfied that the above information is correct and factual. The sum assured is proportionate to the income of proposer and no moral hazard exists.

- All the medical examinations and other clinical tests conducted to finalize the proposal are of the proposer and genuine in every respect.

- That I have followed the requirements/guidelines of Anti-Money Laundering Ordinance of 2018 (AMLO 2018) *and Counter Finance Terrorism (CFT)* as prescribed by SECP and taken all possible precautions to ensure compliance with AMLO 2018.

- I have verified to the best of my knowledge, that the identity of prospect is not fictitious.

- I have verified all the copies of submitted documents required for this proposal against the original documents.

It is my recommendation that the above proposal be accepted on the basis of information provided by the proposer and duly verified by me.

Dated:_____

Place:_____

Signatur
Name: _
Designat
Stamp__

State -

Countersigning by Area Manager / Sector Head / Zonal Head

I hereby certify the authenticity of the above report and recommend the above case for approval.

I have read the '*Declaration*' above and agree with the terms & conditions declared. I understand that by signing below I agree to share the responsibility as stated in the last 'para' of the Declaration

Dated:_____

Signature:_____
Name: _____
Designation: _____
Stamp:_____

STATE LIFE
Insurance Corporation of Pakistan

Annexure "D"

Swiss Re Financial Questionnaire for Proposer

Part 1 – To be completed in all cases

1. Proposal number _____

   Date of Proposal _____

   Full name of life to be insured:

   _____

2. Please give details of occupation and state whether you are employed, a shareholding director or in a partnership:

   _____

3. Are any concurrent applications being made to other offices? YES / NO

   If YES, please give details:

Company	Policy type and term	Sum insured	Reason for cover

4. Please give details of existing policies for life, critical illness and income protection:

Company	Date effected	Policy type and term	Sum insured cover	Reason for

Please also list any other companies which the life insured has been insured with during last 5 years _____

5. **Business details:**

Name of company / partnership _____

Nature of business_____

When was the business established?_____

Number of employees_____

What percentage of the company's share capital does the life to be insured own

_____%

Please attach a structure chart of all companies, partnership, or entities involved in the group, the ownership of each, and how they are related.

6. Please give detail of the turnover, gross profit, and net profit before tax for the last 3 years, and projected figures for the next financial year:

Year	Turnover	Gross Profit	Net Profit before tax	Projected Figures

If a gross or net loss has been reported in these figures, please forward copies of the last two years accounts and an explanation as to why the loss occurred.

Where information is unavailable due to recent formation of the company, please forward a copy of the current business plan including projections.

7. Please give details of the life to be insured's personal earnings as assessed for income tax for the last two years:

	Year_____	Year_____
Salary or package		
Dividends		
Bonuses / commissions		
Share of profit		
Other (please give details)		
Total_____		

8. **Please estimate the value of your assets and liabilities:**

Description	Estimated Value
Assets	
Liabilities	

Please attach a list detailing personal and business assets at market value, together with copies of valuation certificates, if available.

9. Please give details of your dependents including their ages:

Name_____ Age _____ Relationship_____

Name_____ Age _____ Relationship_____

Name_____ Age _____ Relationship_____

Name_____ Age _____ Relationship_____

Name_____ Age _____ Relationship_____

10. Is the life insured or the proposed policy owner currently bankrupt or a director of a company in receivership, or has been so in the past?

If YES, please give detail _____ YES/NO

_____

11. How long is the proposed policy expected to be in force? _____ years

What is the source of premium payments? (Please tick)

Company	
Life insured (self)	
Borrowing	Please state source _____

Is it intended to obtain a tax deduction for premiums? YES/NO

12. What is the reason for affecting this policy? (Please tick)

- o Personal / family protection
- o Key-person protection
- o Loan protection
- o Share purchase / partnership protection

I agree to inform the corporation in writing of any change in my circumstances between the date of this proposal and issue of the policy contract. I understand that cover will not commence until the first premium has been received and the policy or acceptance letter has been issued.

Signature of life to be insured:

_____

Name of Proposer:_____ Date _____

Status of signatory_____

Signature of third party:_____ Date _____

Qualification_____

I confirm to the best of my knowledge that the information contained herein is correct and is supported by evidence provided by the life to be insured and which forms the basis of statutory information and taxation returns. I understand that State Life Insurance Corporation of Pakistan and its reinsurer will rely on this information in assessing the proposal for insurance cover applied.

(Signature of Life to be insured)

STATE LIFE
Insurance Corporation of Pakistan
_____ZONE

Annexure "C"

ZONAL HEAD'S DIRECT CONFIDENTIALREPORT

PROPOSAL NO. _____ Name: _____ CNIC No. _____

Address: _____

RIDERS: TIR ( ) PIB ( )SUM ASSURED_____ TSAR_____

1. Life Proposed's Name_____
2. Telephone No: Office _____Residence_____
3. (a). Mobile_____ Fax _____ Email _____

a. Details of Declaration of Assets:(Place tick/ in the corresponding box)

Residence: Flat ☐ House ☐ Insured Yes ☐ No ☐ Insurance Company_____

Built/purchased in year _____ Inherited. Yes ☐ No ☐ Mortgage/Lien: Yes ☐ No ☐

If 'yes' Mortgage amount: _____ Name of Bank _____

Self-owned ☐ Family owned ☐ Owned since (approx. No. of years)_____

Registered owner _____ Estimated Net worth _____

Additional remarks: _____

Commercial/rental Property: House ☐ Shop ☐ Warehouse ☐ other_____

Self-owned ☐ Family owned. ☐ Owned since (approx. No. of years) _____

Mortgage/Lien Yes ☐ No ☐ Registered owner _____

Rental income/month Rs._____ Estimated Net worth Rs._____

Additional remarks: _____

b. Business/es: Factory Yes ☐ No ☐ If Other (specify) _____

Ownership: Sole ☐ Partnership ☐ Mortgage/Lien Yes ☐ ☐
If yes Amount_____

Establishe[illegible]_____ No of Employees_____ Annual Turnover _____

Registered: Yes ☐ No ☐ Registered owner _____ NTN_____

Registration with Sales Tax: Yes ☐ No ☐ If Yes then Registration No _____

CamScanner

• Estimated Net worth of business in Rs._____ Business Bank Account: Yes ☐ No ☐

Additional remarks. _____

Vehicles:

(3) Make _____Year_____ Market Value Rs. _____

(4) Make _____ Year_____Market Value Rs. _____

Insured by (company) _____ No. of years owned: _____

Name of registered owner (V.1)_____ (V.2) _____

Agricultural Machinery: Tractors _____ Trucks _____Trolley _____Other Machinery _____
Estimated Net worth Rs._____ Additional (specify details) _____

_____

C- Investment Portfolio: Stocks ☐ Bonds ☐Certificates ☐Other (specify) _____

Government Guaranteed: Yes ☐ No☐ Ownership: Registered ☐ Bearer ☐

Estimated/Actual Net worth (list individually): _____

_____ _____ _____

Additional remarks. _____ _____

Agriculture Landholding Size (i)_____acres, Location. _____ Deh/Tapo/Tehsil/Distt. _____
Type: Nehri/Barani_____

Size(ii) _____acres, Location: _____ Type: Nehri/Barani _____

Size (iii) _____acres, Location: _____Type: Nehri/Barani _____

Estimated Total (a + b + c) _____

Self-owned. Rs._____Spouse owned: Rs._____

6. Earning members in the family residing in the same house.

Name	Relationship	Occupation	Yearly Income	Policy No. & Name of Insurer (if insured)

7. Life Proposed's Passport No. _____
Date and Place of Issue _____

8. Countries travelled

Country	Duration of Stay	Year	Purpose of Visit

9. State of Health and General Appearance _____

_____

10. Estimated Annual Income _____

11. Is life proposed known to you, if yes since how long _____

12. Remarks regarding social, financial Standing, income and general reputation in the community_____

_____

Declaration by Reporting Officer:

I do hereby declare that the above proposal is canvassed by me and that I am satisfied with the identity of the life proposed. I also declare that the foregoing statements are correct and true to the best of my knowledge and belief.

- I have personally visited and verified the properties (Business/Residence)/ vehicles/Agricultural Land/Investment portfolio etc. as mentioned above in Column No. 3 and I am also satisfied that the above information is correct and factual. The sum assured is proportionate to the income of proposer and no moral hazard exists.

- All the medical examinations and other clinical tests conducted to finalize the proposal are of the proposer and genuine in every respect.

- That I have followed the requirements/guidelines of Anti-Money Laundering Ordinance of 2018 (AMLO 2018) *and Counter Finance Terrorism (CFT)* as prescribed by SECP and taken all possible precautions to ensure compliance with AMLO 2018.

- I have verified to the best of my knowledge, that the identity of prospect is not fictitious.

- I have verified all the copies of submitted documents required for this proposal against the original documents.

It is my recommendation that the above proposal be accepted on the basis of information provided by the proposer and duly verified by me

Dated:_____

Place._____ Signature:_____

Name: _____

Designation: _____

Stamp_____

STATE LIFE
INSURANCE CORPORATION OF PAKISTAN
Registered & Supervised by the Securities & Exchange Commission of Pakistan
KARACHI SOUTHERN ZONE

Tel No. : 99217001-19
U.N. No. : 111-555-888

To,

Sub: **POLICY NO:** _____

Congratulation on the wise decision of taking the Life Insurance police, providing financial protection to you and your beloved ones.

Balance of some amount is lying in our suspense account to be refunded to you. A provisional receipt with following details was/were issued against the proposal under the above Policy.

1. P.R. No. _____
2. P.R. Amount _____
3. Amount Utillzed _____
4. Amount lying in suspense _____

Please detach the perforated discharged voucher form below and return it after proper completion to us to enable us to refund the amount of suspense to you.

Sincerely Yours.

INCHARGE
NEW BUSINESS K. S. ZONE

NEW BUSINESS SUSPENSE REFUND VOUCHER

To,
The Incharge, N. B.
Karachi Southern Zone

Policy No. _____
Risk Date _____
Policyholder's Name _____

Please issue a cheque for Rs._____ being the refund of amount lying in suspense account under P. R. No. _____ dated _____ (original enclosed) payable in my Bank Account No. (Current/PLS/SB) _____ with _____

(Bank's Name and Address)

Encl: 1. Attached copy.of C.N.I.C.
2. Original P. R.

Date _____
Place _____
Witnessed By :
Name : _____
Address : _____

_____
Policyholder's Signature

Name: _____
Address: _____

NB-42
10-P-10-H

(Please make sure that your signature tally with those registered with us)

Incharge / Functional Head
Policy Holder's Service Department (KSZ)
State Life Building No.2 Wallance Road.
Karachi-74000

RE: APPLICATION FOR REFUND OF SUSPENCE AMOUNT.

POLICY NO											

I Mr./Mrs./Miss. _____ Request to State Life Insurance Corporation of Pakistan, Karachi Southern Zone, to refund a sum of Rs. _____ (Rupees _____ Only) Which is lying in suspense account of my subject mentioned policy.

My Banker's details are here under:

Name of Bank: _____ Branch Code: _____

Branch Address: _____

A/C No: _____ CNIC No: _____

Yours faithfully,

Signature of Policyholder

Date: _____

Address: _____

_____

BANK CERTIFICATE

Certified that Mr./Mrs./Miss _____ whose signature appears above on this application form. His / Her account No _____ With our bank and his/ her signature is verified.

Seal & Signature of Bank Manager

Name: _____

Bank Name: _____

Branch Code: _____

Branch: _____

STATE LIFE
INSURANCE CORPORATION OF PAKISTAN
KARACHI SOUTHERN ZONE

Telephone :99217022
Telephone :99217039
Fax :99217025
Email :slicksz@cyberaccess.com.pk

SURVIVAL CERTIFICATE

POLICY NO. _____

Certified that Mr/Mrs._____ son/ wife

Of Mr._____NIC NO._____

Resident at _____

is alive_____.

Date_____ **Signature of Claimant**

Counter Signed by_____

Name & Designation_____

_____

Official Seal_____

ATTESTED NIC COPY OF CLIAMANT.

N.B. This Certificate should by a Government Doctor, A Magistrate, A Judge,or a Class-1 Gazzeetted Officer, who should also affix his official seal.

STATE LIFE

Insurance Corporation of Pakistan
Agency Administration
Karachi Southern Zone

Field Medical Scheme

HEALTH CARD # _____

Picture

Name: _____

Sales Manager's code: _____

Age: _____ YEARS

Area Manager's code: _____

Issue on:

C.N.I.C. NO: [ ][ ][ ][ ][ ]-[ ][ ][ ][ ][ ][ ][ ]-[ ]

Office Address: _____

Residence: _____

Phone (Off.) _____ Mobile: _____

Sr.#	Name of family member	Relation	Age	C.N.I.C. #	Signature/ Thumb Impression
1					
2					
3					
4					
5					
6					

This card issued under State Life SE's/SM/SSRs (Medical Attendance Scheme) Office Order No. MKTG/PO/50/2002 dated 13-07-2002 is valid up to 31-12-2022 is valid upto _____

I hereby declare that aforementioned persons are under my financial support are residing with me. They don't have any other source of income.

I hereby also declare that whenever any of the aforementioned persons gets any job or get married or dies of gets any other source of income, then I will inform the Corporation at the earliest.

And with effect from that date He/She will not be eligible for the benefits and facilities under State Life Policy applicable to field officers. In case of violation of above statement on my part, management reserves the right to take disciplinary action as per contract of S.M.

FOR PARENTS: Specialist fee Clinical test, Hospitalization No Allowed.

Date: _____

Signature of Field Officer

Signature & Stamp of Authorised Officer
(Agency Admin.)

AREA MANAGER

SECTOR HEAD

The Manager,
New Business Department,
KSZ Zone.

Proposal number ___ has been submitted along-with copies of CNIC (The validity of which stands expired) and *Token* for renewal duly issued by NADRA.

I request you to consider the same for processing the proposal. I assure you and undertake that I shall ensure to submit a self attested and duly verified copy of renewed CNIC, within 03 months of policy issuance. If I fail to do so, my undertaking in subsequent proposal(s) shall not be entertained.

Thanking you,

Signature
(Name of Area Manager)
Area Code Number

The Manager,
New Business Department,
_____ Zone.

Proposal number _____, has been submitted along-with copies of CNIC (The validity of which stands expired) and *Token* for renewal duly issued by NADRA.

I request you to consider the same for processing the proposal. I assure you and undertake that I shall ensure to submit a self attested and duly verified copy of renewed CNIC, within 03 months of policy issuance. If I fail to do so, my undertaking in subsequent proposal(s) shall not be entertained.

Thanking you,

Signature
(Name of Area Manager)
Area Code Number

CERTIFICATE FOR MONTHLY DRIVER'S SUBSIDY

FOR SALES MANAGERS.

_____ Zone

This is to certify that I have qualified for Driver Subsidy for the Year _____, on the performance of the Year _____. I am maintaining Car Registration No._____. I have engaged a Driver on a monthly remuneration of Rs._____.- It is requested to reimburse me the amount of Driver Subsidy for the Month of _____.

Signature : _____

Name : _____

Code No. : _____

Recommended by:

Signature & Seal of the Area Manager : _____

Signature & Seal of the Sector Head : _____

Date: _____

Manager (PHS)
State Life Insurance Corporation of Pakistan
_____ Zone

SUBJECT: WAIVER OF LATE FEES IN POLICY NO. _____

ON LIFE OF MR. _____

Dear Sir

It is submitted that due to certain domestic problem and financial crises, I could not deposit the due premium under subject mentioned policy. Therefore, you are kindly requested to consider my request and waive late fees as a very special case.

I agree with the conditions that, if I Surrender, avail policy loan/ SB, the policy is matured within THREE Years, the waived late fee will be recovered by the Corporation.

Copy of my CNIC is attached.

I will be grateful for this act of kindness

Yours truly

Name:_____

Policy No. _____

CNIC No. _____

Mobile No. _____

Witness: _____

Name: _____

STATE LIFE
INSURANCE CORPORATION OF PAKISTAN
STATE LIFE BUILDING NO. 2 P. O. BOX NO. 4599, WALLACE ROAD, KARACHI-74000
Telephone : 2415051 - 59
Telegrams : "BEEMAZINDIGI"

DIABETES

Questionnaire 1-K

Name _____

Father's Name _____

Birth date _____

Name and Address of Doctor (Stamp & Sig.)

Please check appropriate answers and, where applicable, give details.

DIAGNOSIS _____

_____

Date of Diagnosis _____ Last Attack _____

CHECK UP FINDINGS (Last Results)	RESULT	DATE	RESULT	DATE
BLOOD GLUCOSE - fasting				
- 2 hour post prandial				
GLYCOSYLATED - HAEMOGLOBIN HbA1c				
GLYCOSUREA - fasting				
- post prandial				
PROTEINUREA				
ACETONUREA				

	NO	YES	Details	Date(s)
Blood Glucose in excess of 16.7 mmol/l (300 mg/100 ml) in the last 6 months	☐	☐		
Under medical supervision?	☐	☐		since _____
Diabetes under control?	☐	☐		since _____
Therapy			Description _____ Dosage _____	
oral hypoglycemics	☐	☐		since _____
Insulin	☐	☐		since _____
other medications	☐	☐		since _____

IMPORTANT: Please describe abnormal findings precisely and, if possible, attach last ECG(s)

Please turn over

	NO	YES	Details		Date(s)
ECG rest	☐	☐	☐ normal	☐ abnormal	_____
exercise	☐	☐	☐ normal	☐ abnormal	_____
Retinopathy	☐	☐	Grade _____		_____
Complications :			Which? _____		
- Diabetic cataract	☐	☐	_____		_____
- Coronary heart disease	☐	☐	_____		_____
- Cerebrovascular disease	☐	☐	_____		_____
- Peripheral artery disease	☐	☐	_____		_____
- Diabetic nephropathy	☐	☐	_____		_____
- Unexplained proteinurea	☐	☐	_____		_____
- Polyneuropathy	☐	☐			_____
History of recurrent keto-acidosis, keto-acidotic or hyperosmolar non-ketotic coma	☐	☐	How often _____	Last?	_____
Coronary, cerebrovascular or peripheral artery disease below age 60 in the family history	☐	☐	☐ Father ☐ Siblings	☐ Mother	
Smoker	☐	☐	☐ Cigarettes	Number per Day _____	
If diabetes not currently insulin dependent (type 2), is insulin likely to be needed in the future?	☐	☐	Please explain _____		

Height: _____ Weight _____

Blood Pressure _____ Date(s) _____ treated ☐

IMPORTANT: Please describe abnormal findings precisely and, if possible, attach ECG(s) as well as results of glucose tolerance tests.

DATE SIGNATURE

STATE LIFE
INSURANCE CORPORATION OF PAKISTAN

Telephone : 241505 - 59
Telegrams : "BEEMAZINDAGI"

STATE LIFE BUILDING NO-2, P.O. BOX 4599, WALLACE ROAD, KARACHI-74000

ARTERIAL HYPERTENSION

Questionnaire 1-L

Name _____

Father's Name _____

Birth Date _____

Name and Address of Doctor (Stamp & Sign.)

Please Check appropriate answers and, where applicable, give details.

DIAGNOSIS ☐ Essential Hypertension ☐ Secondary Hypertension ☐ Malignant Hypertension

Date of diagnosis _____ Last consultation _____

BLOOD PRESSURE READINGS in the last 2 years.

DATE	VALUES	
	SYST	DIAST

DATE	VALUES	
	SYST	DIAST

DATES	VALUES	
	SYST	DIAST

	NO	YES			
Cause unknow	☐	☐	if secondary hypertension: Cause _____		
			☐ Cause still present		
Treatment with Antihypertensives	☐	☐	Which date(s)? _____ since		__ ____
- currently other treatment	☐	☐	if treatment stopped, since		__ ____
Other treatment	☐	☐	Specify Why? _____ since		__ ____
			_____		____
ECG - rest	☐	☐	☐ normal	☐ abnormal	__ ____
- exercise	☐	☐	☐ normal	☐ abnormal	__ ____
Hypertensive or arteriosclerotic Retinopathy	☐	☐	Grade _____		__ ____
Coronary, cerebrovascular or peripheral artery disease below age 60 in the family history	☐	☐	☐ Father ☐ Siblings	☐ Mother	
Smoker	☐	☐	Cigarattes	Number/Day _____	

Height _____ Weight _____

Blood Pressure _____ Treatment Date(s) _____

Telephone : 9217001-19
Telerams : "BEEMAZINDIGI"

STATE LIFE
INSURANCE CORPORATION OF PAKISTAN

STATE LIFE BUILDING NO. 2 P. O. BOX NO. 4599, WALLACE ROAD, KARACHI-74000

Questionnaire 1-K

CHEST PAIN

Name _____

Father's Name _____

Birth Date _____

Name and Address of Doctor (Stamp & Sig.)

Please check appropriate answers and, where applicable, give details.

DIAGNOSIS _____

_____

Initial Attack _____ Last Attack _____

	NO	YES			
	☐	☐	if not, cause? _____		_____
Diagnosis of ischemic heart disease Established	☐	☐			_____
Examinations in the last 5 years:	☐	☐	☐ normal	☐ abnormal	_____
-ECG - at reat	☐	☐	☐ normal	☐ abnormal	_____
- exercise	☐	☐	☐ normal	☐ abnormal	_____
- Chest X-ray	☐	☐	☐ normal	☐ abnormal	_____
- Coronary Angiography					
examinations or coronary surgery planned	☐	☐	Which? _____	When?	_____
			_____		
Limitation of physical activity	☐	☐	Cause ☐ Fatigue	☐ Palpitations	
			☐ Dyspnoea	☐ Syncope	
			☐ Angina pectoris		
Smoker	☐	☐	☐ Cigarettes	Number/Day _____	
Diabetic	☐	☐	_____		_____
Hyperlipidemia	☐	☐		Value _____	
				Value _____	
Absences from work due to cardiovscular disturbances in the last 3 years	☐	☐	Cause? _____	Duration?	_____
Coronary, cerebrovascualr or peripheral artery disease below age 60 in family history	☐	☐	☐ Father	☐ Mother	
			☐ Siblings		

* IMPORTANT: Please describe abnormal findings precisely and, if possible, attach last ECG(s)

Please turn over

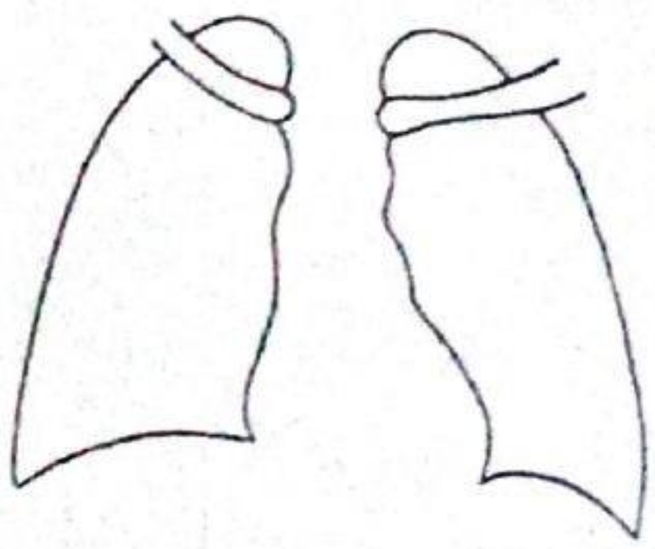
This space is reserved for the Name and Address of the Company

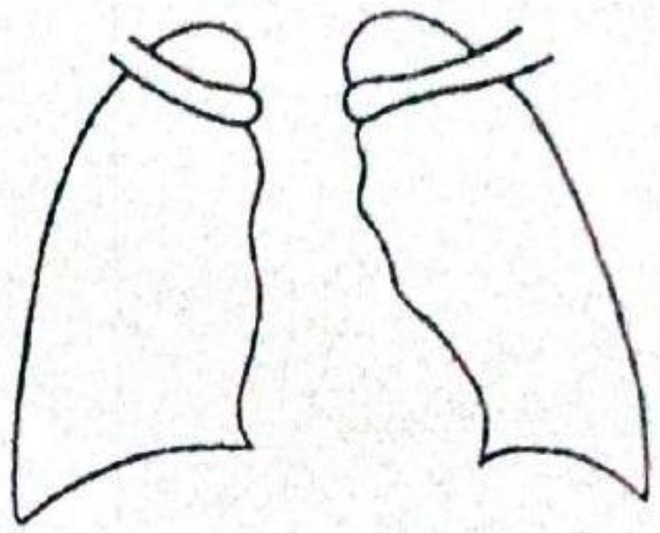
Annexure No.26.

ATTENDING PHYSICIAN'S TUBERCULOSIS QUESTIONNAIRE

Name of Applicant:

Residence:

	Please state full particulars in reply to each question, using an additional sheet, if necessary.
1. How long has the Applicant been under your observation?	1.
2. When was TB first diagnosed?	2.
3. Did the Applicant suffer one or several periods of TB? (Give dates.)	3.
4. On what dates were TB bacilli found?	4.
5. Please mark greatest extent of the disease in the diagram on the right.	5. 
6. Are there any cavities? (If so, state number and locations.)	6.
7. What treatment was administered? (a) Confinement to bed (If so, for how long?) (b) Tuberculostatic treatment (If so, when and for how long?) (c) Surgical therapy (If so, state particulars; in case of pneumothorax state date when pneumothorax discontinued.)	7. (a) (b) (c)

8. Since when can the lung process be regarded as arrested (no changes observed by x-ray)?	8.
9. In the diagram on the right please indicate the present x-ray findings in respect of lungs and pleura.	9. 
10. When last and with what result were the following tested? (a) Sputum (b) Drug resistance (c) Erythrocyte sedimentation rate (d) Lung function	10. (a) (b) (c) (d)
11. Are there any TB lesions in any other parts of the body? (If so, state full particulars).	11.
12. Are there any other complications or any other factors affecting prognosis? (If so, state full particulars.)	12.

Dated at this day of 19

Signature of Attending Physician

Address:

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Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only one of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number

___ - ___ - ___

or

Employer identification number

___ - ___

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here	Signature of U.S. person ▶	Date ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States:

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code* on page 3 and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships* above.

What is FATCA reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code* on page 3 and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account, list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note. ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C Corporation, or S Corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Annexure – No.11

STATE LIFE INSURANCE CORPORATION OF PAKISTAN

DECLARATION TO BE MADE BY A FOREIGN NATIONAL APPLYING FOR PAKISTAN RUPEE POLICY

I hereby declare that I am a bonafide national of _____ and I am present temporarily resident of Pakistan.

I am aware of the following:

1. That any policy where the sum insured is expressed in Pakistan rupees, issued on my life as a foreign national, would be subject to the exchange control regulation of the State Bank of Pakistan, as amended from time to time.

2. That according to the present regulation of a foreign national leaves Pakistan

   a. Premium can be paid only by remitting money from abroad through an authorized dealer of foreign exchange or from the policyholder's non-resident account in Pakistan.

   b. The precedes of the policy are payable in Pakistan rupees to he policyholder's non-resident account in Pakistan

3. That State Life Insurance Corporation of Pakistan cannot undertake to pay the proceeds of a Pakistan rupees policy outside Pakistan or in any currency other then Pakistan rupees.

Dated _____

_____
Signature of the applicant

Witness by _____

Application No._____

_____

Policy No._____