Pak-Qatar Family Takaful Limited

Head Office: 102-105, Business Arcade, Block 6, P.E.C.H.S.,
Sharea Faisal, Karachi, Pakistan,
Phone (92-21) 4311747-56, Fax (92-21) 4386451

Group HEALTH FAMILY TAKAFUL

Out-patient Reimbursement Claim Form

- ☑ To be completed by the covered Individual Member only
- ☑ Do not leave any field blank, questions unanswered, or declaration undated or unsigned (wherever applicable).

Employer's Name:	
Employee Name:	**Instructions:**
Residential Address:	
Contact Number (Daytime):	**E-mail:**

1. Each expense must be itemized on this form and substantiated by a written statement from the provider of the qualifying product or service certifying:
   - The date the product or service was provided
   - A description of the product or service provided
   - The amount charged
   - The name of the provider
   - The name of the person to whom it was provided
2. Incomplete information/document(s) will not be accepted for claim substantiation. Attach bills, receipts, and/or attending physician statements.
3. Please be sure to sign and date this form.
4. Please make a photocopy of the reimbursement form and documentation for your records. Your completed Reimbursement Form and supporting documents must be submitted to the following address, to ensure prompt reimbursement:

Important:
Your claim will not be entertained/processed unless all of the above listed elements are clearly identified on your receipt.

Participant Benefit Services Department (Health)
Pak-Qatar Family Takaful Limited,
102-105, Business Arcade, Block 6, P.E.C.H.S.,
Sharea Faisal, Karachi, Pakistan

DATE EXPENSE INCURRED DD-MM-YY	SERVICE PROVIDER (clinic, pharmacy, doctor, Store etc.)	DESCRIPTION OF EXPENSES	RECEIPT NO	PATIENT'S RELATION TO PARTICIPANT	AMOUNT PAID
					Rs.
					Rs.
					Rs.
					Rs.
					Rs.
					Rs.
					Rs.
					Rs.
					Rs.
			TOTAL REQUESTED REIMBURSEMENT AMOUNT		Rs.

Total amount of Claim (In Pak Rupees):

Title of Cheque: ☐ Participant's (Employer) Name ☐ Employee Name

DECLARATION & AUTHORIZATION

I hereby certify that to the best of my knowledge and belief, my statements on this request for reimbursement are complete and true. I understand that I am solely responsible for the validity of claim(s) submitted. I hereby also declare that I am claiming reimbursement only for eligible expenses incurred by myself, and/or covered dependents and that these expenses have not been reimbursed under this plan or any other source or insurance/takaful scheme.

I, the above claimant, hereby authorize any doctor, hospital, clinic, or medical service provider, Takaful/insurance company or any other institution or any person, who has any information or record about me and/or any of my dependents to provide Pak-Qatar Family Takaful Limited with the complete information including copies ot their records with reference to any sickness, accident, disability, any treatment examination, medical investigation advice of healthcare provider. Photocopy of this authorization shall be valid as the original.

Date of Statement: ☐☐/☐☐/☐☐☐☐

Signature of claimant Individual Member
Employee will complete and sign this form on behalf of minor child

Small quantities, of the following items, do not require a physician's prescription to be reimbursed by Takaful Plan.

1. Allergy Medicine or Cold & Flu Medicine, containing analgesic, antihistamine or antitussive formulation
2. Antibacterial cream
3. Balm for treating muscle and joint pain
4. Burn cream or ointment containing antibiotic
5. Diaper rash ointment
6. Foot preparations containing antifungal
7. Gastrointestinal medicine containing antacid, antiflatuent, antidiarrheal, antiemetic, laxative or fecal softener
8. Hemorrhoid treatment, including suppositories and creams
9. Insect bite medication containing Anti-Infective agent
10. Opthalmic preparation
11. Pedialyte or similar formulation for treating an ill child
12. Pain reliever containing aspirin, ibuprofen or acetaminophen
13. Respiratory product containing sympathomimetic
14. Sinus medicine or nasal sinus spray
15. Wart removal