Pak-Qatar Family Takaful Limited

Form DS-1

Disability Claim Form-Employer's Statement

Note :
Please don't leave any blank, unanswered question, date and/or signature, wherever applicable

Section I

1. Policy No. | 2. Name of Policy Holder:
3. Name of Claimant | 4. Designation
5. Phone No. | 6. Fax No. | 7. E-mail address
8. Employee's Name | 9. CNIC No.
10. Employee's Address
11. Employee's Date of Birth | 12. Age | 13. S. No. on list

Section II (to be completed in Full by the Employer)

1. Employee's Date of Appointment
2. Employee's Effective date of Takaful
3. Last day Worked
4. Returned to work on

5. Reason for Stopping Work
6. Gross Earning from Salary/Wages **Rs.** Per Month | 7. Amount of Takaful Cover **Rs.**
7. What is the present employment stats of the employee? ☐ On Duty ☐ On Sick leave ☐ Terminated ☐ Temporary laid off
8. Amount of Claim | 9. Title of Cheque

Claimant Signature:
Name: Telephone No.:
Date of statment:
Company Stamp

Section III (to be completed in Full by the Patient/Employee)

1. Type of disability claim? ☐ Natural (Sickness) ☐ Accidental
2. Please describe how and where the disability/accident occurred

3. **Date of Accident** or the date I **first noticed** the symptoms of this illness was: / / (Day Month Year)

4.(a) Is your accident or illness related to your occupation? ☐ Yes ☐ No
if "Yes", Please explain

5. I (was/have) unable to work because of this disability starting on: / / (Day Month Year)

6. I (returned/was able to return/will be able to return to work on a full time basis on: / / (Day Month Year)

7. On what date did employer discontinue your monthly salary/wages? / / (Day Month Year)

8. I Date I was first treated for this accident or illness / / (Day Month Year)

Treated by ☐ Hospital ☐ Doctor
Name Address

9. Have you ever had the same or similar condition in the past? ☐ Yes ☐ No If "Yes", when

Treated by Hospital Doctor
Name Address

I certify that the above information is true and correct. I AUTHORIZE any doctor, medical practitioner, hospital, clinic, other medical or medically related facility or insurance company or employer having information available regarding the benefit or the diagnosis, treatment or prognosis with respect to any physical or mental condition and/or treatment of me to give Pak-Qatar Family Takaful Limited, or its representatives and all such information. I AGREE that a photographic copy of this Authorization will be valid as the original. This authorization will remain valid for the term of coverage of the policy

Date of Statement : Signature of Employee: Telephone No.