PAK-QATAR
FAMILY TAKAFUL
Together for the Future

Employer's Statement – S-1
(for Disability due to Sickness)

CLAIMANT'S STATEMENT

Completion Instructions:

1. This form may be completed by those having a claim for Disability/ Health benefits as a person covered/participant himself or as Guardian, Assignee, Trustee or a successor of the covered person
2. Separate forms will be required for each Benefit Claim if more than one Takaful supplementary Benefit is covering the event. However only one form is required for all memberships where the member is covered.
3. Please complete the form with legible handwriting, incomplete form may cause delay in processing of death benefits.
4. This form should be duly attested by notary public, Nazim of a union council or above, executive of Pak-Qatar Family Takaful Limited or class I officer of the federal/provincial government.
5. Copies wherever referred below means certified true copies. Documents issued/prepared in any language other than Urdu or English will be accepted only when accompanied by a certified translation in Urdu/English.

Membership Number(s):			
Amount Claimed:			

CLAIMANT'S INFORMATION

First Name: Middle Name: Last Name :	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Married / Divorcee / Widow
Father/Husband's Name:	Employer's Name & Designation:	Birth date : DD/MM/YYYY	Gender: ❑ M ❑ F
Street address: City:			Phone No.: ( )
Correspondence address: City:			Phone No: ( )
			Cell No: ( )
CNIC NO:		Email address:	
Claiming the benefit as:	❑ Self ❑ Guardian ❑ Successor ❑Assignee ❑other (Specify)		
How it occurred (describe the accident/illness in detail) :			Date first occurred/ observed : DD /MM /YYYY
Have you ever had the same or a similar illness? ☐ Yes ☐ No If yes, state when and describe illness			Date last worked : DD /MM /YYYY
Duration of Illness From:	To:		
Remained admitted to Hospital From:	To:		
Remained confined to bed From:	To:		
Remained Confined to home From:	To:		

Type of employment in which you are engaged:	Any work you been able to perform since the onset of disability:

When you expect to return to work:	Your level of education :	Other special training:
DD / MM / YYYY	Date completed: DD / MM / YYYY	

Were you covered by takaful/ insurance from any other company which provides disability benefits? (If the answer is Yes please provide detail below) ❑ Yes ❑ No	Earnings as of date of disability:

Number of Membership/Policy:	Date of Issue:	Company's Name and Address :
1. 2. 3.	DD / MM / YYYY	

Detail of all treatments taken during your current disability :

Doctor/ Hospital Name	Address	Complaint/Illness	Date of treatment
1. 2. 3.			

Please attach a certified copy of the original of the following documents — if available/applicable:

Participant's Membership Document (PMD)	☐ Attached
Hospital record	☐ Attached
Hospital discharge certificate	☐ Attached
Assignment letter (if applicable)	☐ Attached
Copy of CNIC of claimant	☐ Attached
Copy of passport of claimant (if claimant living abroad)	☐ Attached
Copies of police report, newspaper clipping (in case of accident)	☐ Attached
Others:_____	Attached

DECLARATION

I hereby declare that the answers to all the questions were entered completely and truthfully and nothing has been concealed or misrepresented.

I hereby authorize Pak-Qatar Family Takaful Ltd.

1. Knowing that the authorization will be used in determining the eligibility of the payment of death benefit in this(ese) contracts and will be used for processing of these benefits only;
2. To require and collect medical and non medical information regarding the deceased from all hospitals/doctors, medical facilities, federal, provincial and local government agencies, law enforcement agencies, Federal Bureau of Revenue, NADRA, Banks, takaful, insurance Retakaful and reinsurance companies and request all of them to provide all such information pertaining to the deceased;
3. And the deceased had during his life time authorized the company to have access to such information pertaining him.

Signature of Claimant	Name of Attestor
Date	*Address*

I hereby declare that the information set forth herein is trueto the best of my knowledge and belief .

Signature of the Attestor: Year Month Day