



## Part A

- To be completed by the covered individual member only  
 Do not leave any field blank, questions unanswered, or delaration undated or unsigned (wherever applicable).

<b>Type of Claim</b>	<input type="checkbox"/> Pre-hospitalization expenses	<input type="checkbox"/> Hospitalization/Day Care expenses	<input type="checkbox"/> Post Hospitalization expenses
	<input type="checkbox"/> Pre-natal epenses	<input type="checkbox"/> Delivery expenses	<input type="checkbox"/> Post-natal expenses

Claimant Name:	Plan Number:
Participant (Employer) Name:	Plan Start Date:                      Plan End Date:

Patient's Name:	Patient's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Patient's Takaful Certificate Number:	Patient's Date of Birth: <input type="text"/> - <input type="text"/> - <input type="text"/>
CNIC: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Phone Residence:                      Phone Office:                      Mobile:

1. State the nature of the medical condition, injury, illness:

2. On what date did the symptoms first occur?                      CNIC Number:

3. Name and address of physician provider first consulted due to above-mentioned medical condition?

4. Has the patient consulted any doctor for the above-mentioned medical condition?  
 If "yes", for each doctor and hospital consulted. state name, date of consultation, reason for consultation and treatment provided.

Name of Doctor/Hospital:	Date of Consultation	Reason of Consultation	Treatment/Results

5. Is this claim related to an accident?  Yes  No    If "yes". what was the date of the accident?                       -  -

Give brief details of where and how accident occurred?

6. Give detils of any other health, medical of travel Takaful / Insurance, workman's compensation, social security or other medical benefits to which the pateint may be entitled

Name of Hospital, where treatment availed:

Date of Admission	Date of Discharge	Total Nos. of days
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Total Amount of Claim (In Pak Rupees)

### DECLARATION & AUTHORIZATION

I hereby certify that all answers to questions appearing on this form and documents submitted with this form are true and complete to the best of my knowledge and belief.

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 of their records with reference to any sickness, accident, disbaility,any treatments, examination, medical investigation, advice of healthcare provider. Photocopy of this aithorization shall be valid as he original.

**Date of Statement:**  -  -

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

### VERIFICATION BY PARTICIPANT/EMPLOYER

I/We hereby certify that all answers to question appearing on this form are true and complete to the best of my/our knowledge and beilief. We understand and agree that the above statement shall form the basis for Takaful coverage.

**Date of Statement:**  -  -

\_\_\_\_\_  
**Signature of Participant**

**Part B** To be completed by the **Teating Physician** Do not leave any field blank, questions unanswered, or delaration undated or unsigned (wherever applicable).

Patient's Name:	
Patient's Takaful Certificate Number:	Patient's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
CNIC: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Patient's Date of Birth: <input type="text"/> - <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

1. How long have you been the patient's doctor?			
2. On what date were you first consulted for the injury, illness or medical condition concerned or for any related condition?			
3. Please give you diagnosis of the injury/illness/condition?			
4. Do you have any reason to believe that the same or any related condition has been diagnosed or treated previously by any other doctor or hospital?			
5. Has the patient consulted any doctor for the above-mentioned medical condition? If "yes", for each doctor and hospital consulted. state name, date of consultation, reason for consultation and treatment provided.			
Name of Doctor/Hospital	Date of Consultation	Reason of Consultation	Treatment/Results
6. Please give details of the treatment given or prescribed?			

**For Maternity claim only**

1. Duration of Pregnancy? <input type="checkbox"/> 1st Trimester <input type="checkbox"/> 2nd Trimester <input type="checkbox"/> 3rd Trimester	<input type="text"/>	weeks
2. Would normal delivery endanger the life of mother and/or child(ren) and intra-abdominal surgery necessary for extra iterine pregnancy or complications: <input type="checkbox"/> Yes <input type="checkbox"/> No if "Yes", please give reason in detail:		
<input type="text"/>		
3. Is there any permicious vomiting in pregnancy, toxemia with convulsion or spontaneous abortion?: <input type="checkbox"/> Yes <input type="checkbox"/> No if "Yes", please give reason in detail:		
<input type="text"/>		

**DECLARATION**

i/We hereby certify that all answers to questions appearing on this form are true and complete to the best of my/our knowledge

**Date of Statement:**  -  -    \_\_\_\_\_  
**Signature of treating physician**

Name of Physician

PMDC No:

Address:

Contact No:

**IMPORTANT: In order to avoid any delay, Please ensure that:**

Use a New Claim form for each claim or course of treatment

The **Individual Covered** or his/her legal representative must complete all question of Part A of the claim form and sign itThe **treating physician** must complete all questions of Part B of the claim form and sign it.

Please recheck and send fully completed claim form with all relevant document(s)/Report to Pak-Qatar Family Takaful Limited.

Please be informed that;

- Incomplete claim form **CANNOT** be accepted for precessing of payment
- Ensure to attached **ORIGINALS** of all relevant document(s)/Report.
- Ensure to attached **ORIGINAL** bills and receipt of payment)s.
- PHOTOCOPIES** are not acceptable for processing of claim

## Section 5: AML-CFFT REGULATIONS AND TYPOLOGIES

1. Are you or any of your associate immediate family member/s affiliated with any political party, or works for the judiciary, armed forces, law enforcement Agencies or bureaucracy in any possible way?  YES  NO
2. Do you have any criminal record or criminal proceedings pending against you before any adjudicating forum(s) OR associated/linked with any Proscribed organization/Individual referred in shedule IV of the Anti-Terrorism Act 1997 or as per any other prevailing law of the land?  YES  NO
3. Are you subject of any money laundering or terrorist financing-related proceedings, investigation, sanctions, punitive action indictment, had fines, conviction or civil enforcement action imposed on you by a enforcement body? (if YES fill in the details below)  YES  NO

Typologies work is the study of methods, techniques and trends of money laundering and terrorist financing. The research of the following typologies has been undertaken for better understanding the money laundering and terrorist financing enviroment in the Asia Pacific region the following are a few key money laundering and terrorist financing methods, techniques, scheme and instruments:-

Please tick  where appropriate

Narcotics and Trafficking	
Kidnapping for ransom	
Corruption and Bribery	
Robbery / theft	
Smuggling in relation to Custom and Excise Duty and taxes	
Extortion for business	
Tax Crime related to direct and indirect taxes	
Cyber crime	
Illegal MVTS/Hawala/Hundi	
Insider Trading and market Manipulation	
Cash Smuggling:	
Terrorism and Terrorism Financing	

Terrorism and Terrorism Financing	
Illicit Trafficking in stolen and other goods	
Sexual Exploitation, Including Sexual Exploitation of Children	
Counterfeiting Currency	
Participation in an organized criminal group and racketeering	
Counterfeiting and Piracy of Products	
Human Trafficking / Migrant Smuggling or Trafficking in Person	
Murder, Grievous Bodily Harm	
Illicit Arm Trafficking	
Environmental Crime	
Fraud/Forgery / Cheating	
Piracy	

If answered 'YES' to Option no. 3 and accordingly selected any of the options above then please share the below details:-

Dealing Court/Agency: \_\_\_\_\_

Nature \_\_\_\_\_

Title \_\_\_\_\_

Year \_\_\_\_\_

City \_\_\_\_\_

# Complaints in Respect of Takaful Membership

# تکافل ممبر شپ کے متعلق شکایات

If you have any complaint or grievance against the Takaful Company, agent, or bank representative in respect of your Takaful Membership, you may file your complaint directly with the Takaful Company at the following address:

اگر آپ کو اپنی تکافل ممبر شپ کے حوالے سے تکافل کمپنی، ایجنٹ یا بینک نمائندے سے کوئی شکایت ہو تو سب سے پہلے متعلقہ تکافل کمپنی کو براہ راست اپنی شکایت درج ذیل پتہ پر بھیجیں

## Pak-Qatar Family Takaful Limited

## پاک قطر فیملی تکافل لمیٹڈ

Complaint Handler; Mr. Kashif Rasheed,  
Incharge Complaint Cell  
102-105, Business Arcade, Plot # 27-A, Block 6, P.E.C.H.S., Sharea Faisal,  
Karachi. 75400. **Phone:** 021-38798550  
**Email:** kashif.rasheed@pakqatar.com.pk, complaints@pakqatar.com.pk

جناب کاشف رشید صاحب  
انچارج مرکز شکایت

لیگل اینڈ کیپٹالس ڈیپارٹمنٹ 102، 105 بزنس آرکیڈ، پلاٹ نمبر 27-A، بلاک 6، P.E.C.H.S. شاہراہ فیصل کراچی 75400۔ فون: 021-38798550  
ای میل: kashif.rasheed@pakqatar.com.pk  
complaints@pakqatar.com.pk

However, in case if the insurance company fails to address your grievance, you may file your complaint with other external independent forums at the following addresses:

اگر انشورنس کمپنی آپ کی شکایت کا ازالہ کرنے میں ناکام رہے یا آپ کمپنی کے جواب سے مطمئن نہ ہوں تو آپ مندرجہ ذیل اینڈینڈنٹ فورم کے ساتھ اپنی شکایت کا اندراج کروا سکتے ہیں

## Federal Insurance Ombudsman

## وفاقی انشورنس محتسب

2nd Floor, Pakistan Red Crescent Society, Annexe Building, Plot # 197/5,  
Dr. Doud Pota Road, Karachi  
**Phone:** 021-99207761-62 | **Website:** www.fio.gov.pk/

سیکنڈ فلور، ریڈ کرسینٹ سوسائٹی  
انکسی بلڈنگ، پلاٹ نمبر 197/5 ڈاکٹر دود پوتا روڈ، کراچی۔  
فون: 021-9920771-62۔ ویب سائٹ: www.fio.gov.pk/

**Note:** Policyholders from any part of Pakistan, AJK/Gilgit Baltistan may approach FIO

نوٹ: پاکستان کے کسی بھی علاقے تعلق رکھنے والے پالیسی ہولڈرز، آزاد جموں کشمیر/گلگت بلتستان وفاقی انشورنس محتسب (ایف آئی او) سے رجوع کر سکتے ہیں۔

## Official Coordinator, Small Disputes Resolution Committee – Karachi

## دفتری رابطہ کار-کراچی

Specialized Companies Division, 5th Floor, State Life Building No. 2, Wallace  
Road, Off. I. I. Chundrigar Road, Karachi.  
**Phone:** 021-32414204 | **Email:** sdrc.khi@secp.gov.pk

سال ڈیویژن ریگولیشن کمیٹی  
اسپیشلائزڈ کمپنیز ڈویژن 5<sup>th</sup> فلور، اسٹیٹ لائف بلڈنگ نمبر 02 ولاس روڈ، آئی آئی چندریگر روڈ، کراچی  
فون: 021-32414204 ای میل: sdrc.khi@secp.gov.pk

**Note:** Policyholders belongs to provinces of Sindh and Baluchistan may approach this Committee

نوٹ: صوبہ سندھ اور بلوچستان سے تعلق رکھنے والے پالیسی ہولڈرز کراچی میں قائم کمیٹی سے رجوع کریں۔

## Official Coordinator, Small Disputes Resolution Committee – Lahore

## دفتری رابطہ کار-لاہور

Company Registration Office – Lahore, Associate House, 3rd & 4th Floor,  
7-Egerton Road, Lahore.  
**Phone:** 042-99204962-66 **Email:** sdrc.lhr@secp.gov.pk

سال ڈیویژن ریگولیشن کمیٹی  
کمپنی رجسٹریشن آفس، لاہور  
ایسوسی ایٹ ہاؤس، 3<sup>rd</sup> فلور 4 ایجنڈ 7 ایگرتن روڈ، لاہور۔  
فون: 042-99204962-66 ای میل: sdrc.lhr@secp.gov.pk

**Note:** Policyholders from all districts of Punjab except Bhakkar, Khushab, Mianwali, Jhelum, Chakwal, Rawalpindi and Attock may approach this Committee

نوٹ: بھکر، خوشاب، میانوالی، جہلم، چکوال، راولپنڈی اور اٹک کے سوا پنجاب کے تمام اضلاع کے پالیسی ہولڈرز لاہور میں قائم کمیٹی سے رجوع کر سکتے ہیں۔

## Official Coordinator, Small Disputes Resolution Committee – Islamabad

## دفتری رابطہ کار-اسلام آباد

Insurance Division, 3rd Floor, NIC Building, 63-Jinnah Avenue, Blue Area,  
Islamabad. **Phone:** 051-9207091-4 **Email:** sdrc.isb@secp.gov.pk

سال ڈیویژن ریگولیشن کمیٹی  
سیکیورٹیز اینڈ ایکسچینج کمیشن آف پاکستان 3<sup>rd</sup> فلور، این آئی سی بلڈنگ 63 جناح ایونیو  
بلیو ایریا، اسلام آباد۔ فون: 051-9207091-4 ای میل: sdrc.isb@secp.gov.pk

**Note:** Policyholders belonging to Islamabad Capital Territory, Khyber Pakhtunkhwa, Gilgit Baltistan, Azad Jammu & Kashmir and the western side of Punjab (i.e. Bhakkar, Khushab, Miawali, Jhelum, Chakwal, Rawalpindi and Attock districts) may approach this Committee

نوٹ: اسلام آباد کیپیٹل ٹیریٹری، خیبر پختونخوا، گلگت بلتستان، آزاد جموں کشمیر، اور صوبہ پنجاب کے مغربی حصے (یعنی بھکر، خوشاب، میانوالی، جہلم، چکوال، راولپنڈی اور اٹک اضلاع) سے تعلق رکھنے والے پالیسی ہولڈرز اسلام آباد میں قائم کمیٹی سے رجوع کر سکتے ہیں۔

Complaint against Takaful Company may also be filed with Securities and Exchange Commission of Pakistan (insurance regulator in Pakistan) at the following address:

انشورنس کمپنی کے خلاف شکایت سیکیورٹیز اینڈ ایکسچینج کمیشن آف پاکستان (جو کہ پاکستان میں انشورنس ریکولیٹری کا ریگولیٹر ہے) کے پاس بھی درج ذیل ایڈریس پر دائر کی جاسکتی ہے۔

## Securities and Exchange Commission of Pakistan (SECP)

## سیکیورٹیز اینڈ ایکسچینج کمیشن آف پاکستان

NIC Building, 63-Jinnah Avenue, Blue Area, Islamabad.  
**Phone:** Toll free 080088008/051-9207091-4  
**Email:** complaints@secp.gov.pk  
https://sdms.secp.gov.pk/ (for online filing of complaints)

این آئی سی بلڈنگ 63 جناح ایونیو، بلیو ایریا، اسلام آباد۔  
فون: ٹول فری 080088008/051-9207091-4  
ای میل: complaints@secp.gov.pk  
ویب سائٹ: https://sdms.secp.gov.pk/ (شکایات کی آن لائن فائلنگ کے لیے)

**Note:** Policyholders from any part of Pakistan, AJK/Gilgit Baltistan may approach SECP

نوٹ: پاکستان کے کسی بھی علاقے سے تعلق رکھنے والے پالیسی ہولڈرز، آزاد جموں کشمیر/گلگت بلتستان بس ای سی پی سے رجوع کر سکتے ہیں۔