



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

## Section I. Policy holder's information

Name of Policy Holder		
Takaful Policy No.	Takaful Policy Commencement Date.	
Designation.	Phone No / Mobile No	E-mail address
Employee's Name.		CNIC.
Employee's Address		
Employee's Date of Birth	Age	S. No. on list

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

Employee's Date of Appointment	DD-MM-YYYY	Employee's Effective Date of Takaful	DD-MM-YYYY	Last Day Worked	DD-MM-YYYY	Returned to Worked	DD-MM-YYYY
Reason for Stopping Work							
Gross Earning from Salary/Wages	Rs. _____ PerMonth	Amount of Takaful cover	Rs. _____	What is the present employment stats of the employee			
				<input type="checkbox"/> On Duty	<input type="checkbox"/> Terminated		
				<input type="checkbox"/> On Sick Leave	<input type="checkbox"/> Temporary Laid off		
Amount of Claim		Title of Cheque					
Claimant Name _____						Telephone No _____	
Date of Statement _____							
Employer Signature _____						Company Stamp	

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

Type of disability claim?	<input type="checkbox"/> Natural (Sickness)	<input type="checkbox"/> Accidental
Please describe how and where the disability/accident occurred _____		
Date of Accident or the date I first Noticed the symptoms of this was:	DD-MM-YYYY	(a) Is your accident or illness related to your occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No if "Yes", Please explain
I (was/have) unable to work because of this disability starting on	DD-MM-YYYY	
On What date did employer discontinue your monthly salary/wages	DD-MM-YYYY	I (returned/was able to return/will be able to return to work on a full time basis on
Date I was first treated for this accident or illness	DD-MM-YYYY	Treated by <input type="checkbox"/> Hospital <input type="checkbox"/> Doctor
		Name _____ Address _____
Have you ever had the same or Similar condition in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", when	Treated by <input type="checkbox"/> Hospital <input type="checkbox"/> Doctor
		Name _____ Address _____
I certify that the above information is true and correct. I AUTHORIZE any doctor, medical practioner, hospital, clinic, other medical or medically related facility or insurance company of employer have 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 respresentatives and all such information. I AGREE that a photographic copy of this Autihorization 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.

### PAK-QATAR FAMILY TAKAFUL LIMITED

102-105, Business Arcade, Block-6, P.E.C.H.S, Shakra-e-Faisal, Karachi 75400, Phone: (92-21) 34311747-56 (Ext-162)  
Fax: (9221) 34386451, UAN: 021-111-TAKAFUL (825238), Email: life.claims@pakqatar.com.pk, www.pakqatar.com.pk