PAK QATAR GENERAL TAKAFUL LIMITED
PERSONAL ACCIDENT Death CLAIM FORM

Policy Certificate No._____ Claim No._____

(The company does not warrant admission of liability by the issuance of this form)

1. Name of Participant (in full) ……..……..… Ufone #.....

Address of Residence ……..…… Date of Birth……..

Name & Address of Business ……..……

……CNIC …… Occupation ……

If more than one occupation, state all ……..……

(Pointers 2 – 8 required in case of Accidental Disability)

2. (a) Date, time and place of accident / Injury (b) Give particulars of the cause, and the injuries sustained	
3. Names and addresses of any Witnesses of the accident (if any)	
4. Name and address of the Doctor attending the patient	
5. State where and when a Medical or other officer of the Company can visit you, if necessary.	
6. (a) State the period during which you or patient have been totally disabled from attending to your business as the sole and direct result of the accident. (b) Are you still totally disabled? If not, from what date were you able to attend to some part of your business?	
7. Have you/patient previously claimed or received compensation under an Accident and/or Sickness Policy? If so, please give particulars.	
8. (a) Are you/patient covered from elsewhere? (b) If so, give the name of each Company , and amount entitled to claim.	

P.S. The MEDICAL CERTIFICATE from the attending physician is to be furnished at the expense of the participant/beneficiary/claimant.

(Pointers 9 – 12 required in case of Accidental Death)

9 (a) Date, time and place of accident / Injury / (b) Give particulars of the cause of death	
10. Brief description of occurrence of accident	
11. Name and address of Hospital & Doctor attended the patient	
12. (a) Did police investigated the incident? If yes, please provide the name of police station & investigation officer. (b) Did post mortem take place? If yes, please provide the copy of report	

P.S. The MEDICAL CERTIFICATE from the attending physician is to be furnished at the expense of the participant/beneficiary/claimant.

I, the undersigned, do hereby declare that, to the best of my knowledge and belief, the foregoing particulars are true and correct.

I authorize any insurance/Takaful company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the deceased to release any information requested regarding this claim and the loss reported. I understand this information will be used by the Pak Qatar General Takaful, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim.

I understand that any person who knowingly and with intent to defraud or deceive any insurance/Takaful company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for fraud.

Name & Relation with Participant …….....
(In case the claimant is different from Participant):

Contact Number: ……..

CNIC # …….

Signature & Date: ……

PRIVATE AND CONFIDENTIAL

MEDICAL CERTIFICATE TO BE COMPLETED BY PARTICIPANT'S DOCTOR

It is understood that this certificate will be completed on the basis of your existing knowledge and without undertaking any future examination.

I CERTIFY that ……...was

injured/dead due to accident on ……

with having injuries ……

ACCIDENTAL DISABILITY

He is solely and directly totally disabled on a result of the injuries and will be so disabled until ……

……

ACCIDENTAL DEATH

He could not sustained injuries on …….. and could not survive to his life.

Name & qualification: …….Signature: ……

Hospital Name & Stamp:…… Date……

Total disablement occurs when the PARTICIPANT is wholly prevented from attending to his business or occupation.