Pak-Qatar Family Takaful Limited

Form DS-1

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: Salman Rasheed | 9. CNIC No.: 14302-9842076-9
10. Employee's Address: Distt, Kohat Teh, Lachi P/o Lachi, village Boughdi Khurd
11. Employee's Date of Birth: 08/04/1990 | 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
01/06/2019	13/06/2019	05/11/2019	04/12/2019

5. Reason for Stopping Work: Due to road traffic accident left hand bone fracture.
6. Gross Earning from Salary/Wages: Rs. 50400/- 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: when I was returing home from my field work, The accident taken place on the road.

3. **Date of Accident** or the date I **first noticed** the symptoms of this illness was: 05 / 11 / 2019 (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: 05 / 11 / 2019 (Day Month Year)

6. I (returned/was able to return/will be able to return to work on a full time basis on: 04 / 12 / 2019 (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: 05 / 11 / 2019 (Day Month Year)

Treated by ☐ Hospital ☑ Doctor
Dr Fahad Ajmal
Name | Address

9. Have you ever had the same or similar condition in the past? ☐ Yes ☐ 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: 13/01/2020 Signature of Employee: [signature] Telephone No. 03340902954

Ref No.: GT/CL/2008/00053/1

Pak-Qatar Family Takaful Limited

FAMILY TAKAFUL

Form DS-2

Physician's Statement

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

Patient Information

Name of Patient: Salman Rasheed

Date of Birth: 08/04/1990

Patient's Address: Disst Kohat, Teh Lachi P/o Lachi village Boraghar Khurd

Employer Information

Name of employer:

1. History

(a) Date doctor first consulted due to disability: 05 (Day) 11 (Month) 2019 (Year)

(b) Date symptoms first appeared or accident happened: 05 (Day) 11 (Month) 2019 (Year)

(c) Date patient ceased work because of disability: 06 (Day) 11 (Month) 2019 (Year)

(d) Has patient ever had same or similar condition? ☑ No ☐ Yes, state when and describe

(e) Is condition due to injury or sickness arising out of patient's employment? ☑ Yes ☐ No ☐ Unknown

(f) Name the first doctor with full address, consulted by the claimant for the above disability/Accident?
Dr Fahad Ajmal, Raiz clinic Lachi
Name of Doctor / Address
Mobile No. 03361010200

2. Diagnosis

(a) Date of Last examination/Consultation: 20 (Day) 11 (Month) 2019 (Year)

(b) Diagnosis (including any complications): Fracture Radius and Ulna left

(c) Subjective symptoms: Road Traffic accidant. Pain left forearm

(d) Objective findings (including current X-rays, ECG's, laboratory data and any clinical findings):
(1). Clinical Findings: Deformity left forearm.
(2). Diagnostic studies and results: Fracture shafts of Radius & Ulna left

3. Progress

(b) Patient is ☐ Ambulatory ☐ Bed confined ☐ House confined ☐ Hospital confined

(a) Patient has ☐ Recovered ☑ Improved ☐ Stabilized ☐ Retrogressed

4. Prognosis

(a) Is the disability presumed to be reversible? ☑ Yes ☐ No

(b) Is patient now capable of performing duties of ☐ Yes ☐ No His or Her Current Job ☐ Yes ☐ No *Any other job for which he or she is reasonably suited or qualified by education, training or experience

(c) What duties of his or her job is patient incapable of performing?

(d) Do you expect a fundamental or marked change in future? ☐ Yes ☑ No
If "Yes", patient should recover sufficiently to perform duties on or about _____ (Day) (Month) (Year)
If "No", please explain: Fx R/U opacted and will unite.

(e) Specify the date by which you presume that the patient will be able to resume his duties/work:
☑ Totally ☐ Partially ☐ Temporarily ☐ Permanently 05/12/19

Remarks

INCHARGE
Rehman Orthopedic Hospital
Dr. Rehman Afridi
MBBS, FCPS

Declaration : I hereby declared that the above statements are true and complete to the best of my knowledge

Signature: Umair Jaleel	Date: 13/01/2020
Attending physician's name: Dr. Rehman	Specialty: Orthopaedic Surgeon
Address: Rehman Orthopaedic Hospital KDA Kohat	Telephone No. 03339610969

Ref No.: GT/CL/2008/00054/1