PAK-QATAR
FAMILY TAKAFUL
Together for the Future

Employer's Statement – DS1 (Disability Claim Form)

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: Samina		
Takaful Policy No.	Takaful Policy Commencement Date.	
Designation. CHW	Phone No / Mobile No	E-mail address
Employee's Name. Samina		CNIC. 15201-4276758-2
Employee's Address		
Employee's Date of Birth 29-3-1988	Age	S. No. on list

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

Employee's Date of Appoinment: 27 Sep 2023	Employee's Effective Date of Takaful: till date	Last Day Worked	Returned to Worked
Reason for Stopping Work			
Gross Earning from Salary/Wages Rs. 32,000 Per Month	Amout of Takaful cover Rs.	What is the present employment stats of the employee	☐ On Duty ☑ On Sick Leave ☐ Terminated ☐ 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? ☐ Natural (Sickness) ☑ Accidental

Please describe how and where the disability/accident occured: HOR ulnar styloid #

Date of Accident or the date I first Noticed the symptoms of this was: 27/march/2024	(a) Is your accident or illness related to your occupation? ☑ Yes ☐ No if "Yes", Please explain: HOR
I (was/have) unable to work because of this disability starting on 27/march/2024	
On What date did employer discontinue your monthly salary/wages 27/march/2024	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 27/march/2024	Treated by ☑ Hospital ☐ Doctor Name: in Emergency Address: LRH pesh
Have you ever had the same or Similar condition in the past? ☐ Yes ☑ No If "Yes", when	Treated by ☑ Hospital ☐ Doctor Name: in Emergency Address: LRH pes

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 confition 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.

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