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			
Takaful Policy No.	Takaful Policy Commencement Date		
Designation CHW	Phone No / Mobile No 03338329739	E-mail address	— NA
Employee's Name AZRA AKHTAR		CNIC 54401-3578186-6	
Employee's Address Killi Habib Kaichi baig. Dakhana Saryab Tehsil District Quetta			
Employee's Date of Birth 23-04-1997 Age 27	S. No. on list		

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

Employee's Date of Appointment 01-07-2023	Employee's Effective Date of Takaful	Last Day Worked No Leave taken working on daily basis-	Returned to Worked —
Reason for Stopping Work	She iam present on each activity.		
Gross Earning from Salary/Wages Rs. 32000/= 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 AZRA+ 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 Dog bite during field activity during mc updation & mobilisation Activity.

Date of Accident or the date I first Noticed the symptoms of this was: 21Aug.24	(a) Is your accident or illness related to your occupation? ☑ Yes ☐ No if "Yes" Please explain while on field dog bite on leg was referred to hospital for anti rabies & Mall wounds due to bite
I (was/have) unable to work because of this disability starting on —	I (returned/was able to return/will be able to return to work on a full time basis on
On What date did employer discontinue your monthly salary/wages —	Treated by ☑ Hospital ☐ Doctor
Date I was first treated for this accident or illness 21. Aug. 24	Name BMC Address
Have you ever had the same or Similar condition in the past? ☐ Yes ☑ No If "Yes", when	Treated by ☐ Hospital ☐ 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 Authorization will be valid as the original this authorization will remain valid for the term of coverage of the policy

Date of Statement: 6-Nov-2024 AZRA+ Signature of Employee Telephone No 03338329739