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	Naila shah		
Takaful Policy No.		Takaful Policy Commencement Date.	23/8/24
Designation.	Phone No / Mobile No 0333 0496505	E-mail address	
Employee's Name.	Naila Shah	CNIC.	5440189570592
Employee's Address	Barech pull.		
Employee's Date of Birth	10.9.2002 Age 23	S. No. on list	

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

Employee's Date of Appointment 23/8/24	Employee's Effective Date of Takaful	Last Day Worked 23/8/24	Returned to Worked 9/9/24
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 Naila 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

Date of Accident or the date I first Noticed the symptoms of this was: 23/8/24	(a) Is your accident or illness related to your occupation? ☐ Yes ☐ No if "Yes", Please explain
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 23/8/24	Name 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 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 Authorization 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: Naila Telephone No. 03330496505

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