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. UCOO	Phone No / Mobile No 0301-2500009	E-mail address Naeeem341@gmail.com
Employee's Name. Naeemullah		CNIC. 54303-2450711-5
Employee's Address Cadet College Pishin		
Employee's Date of Birth 01-03-1990 Age 34		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 30-09-2024	Returned to Worked 10-11-2024
Reason for Stopping Work: Accident			
Gross Earning from Salary/Wages Rs. _____ PerMonth	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: When we are in Posi Campaign review meeting 9 way going for meeting and accident occurs.

Date of Accident or the date I first Noticed the symptoms of this was: 23-sep-2024	(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 23-sep-2024	During Posi Campaign review meeting the accident occure.
On What date did employer discontinue your monthly salary/wages	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 23-sep-2024	Treated by ☐ Hospital ☑ Doctor Name Dolat hospital Pishin Address Babo Mulla Pishin
Have you ever had the same or Similar condition in the past? ☐ Yes ☐ No If "Yes", when	Treated by ☐ Hospital ☑ Doctor Name Dr. Abdul Ali Kakar Address BMC Quetta.

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: 23-Sep-2024 Signature of Employee: _____ Telephone No. 03012500009

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