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. A-S	Phone No / Mobile No 03158853128	E-mail address asibnaeem10.gmail.com
Employee's Name. M. Asif Khan		CNIC 54201-8664981-9
Employee's Address Guldara Bashicha Chaman		
Employee's Date of Birth 18-02-2000 Age 24	S. No. on list	

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

Employee's Date of Appointment 01/09/23	Employee's Effective Date of Takaful	Last Day Worked 14/09/24	Returned to Worked 19/09/24
Reason for Stopping Work	due to accident		
Gross Earning from Salary/Wages Rs. 34556/- PerMonth	Amout of Takaful cover Rs. 1200/-	What is the present employment stats of the employee	☑ On Duty ☐ Terminated ☐ On Sick Leave ☐ Temporary Laid off
Amount of Claim 90000/-	Title of Cheque		
Claimant Name M. Asif Khan		Telephone No	
Date of Statement 26/09/24			
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 A Bike accident were happend during Campaign of Sept of 14th, 2024. union of Mehmoodabad 1.

Date of Accident or the date I first Noticed the symptoms of this was 14/09/2024	(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 14/09/2024	
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 14/09/2024	Treated by ☐ Hospital ☐ Doctor 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 condition and/or treatment of me to give Pak-Qatar Family Takaful Limited, or its respreseritatives 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 26/09/24 Signature of Employee: Telephone No 03158853128

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