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.		
Designation. chw	Phone No / Mobile No	E-mail address	
Employee's Name. Naila Shah		CNIC.	
Employee's Address: Barech Pull chaloo bawrhi			
Employee's Date of Birth	Age	S. No. on list	

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

Employee's Date of Appoinment: 29.09.2023	Employee's Effective Date of Takaful: DD-MM-YYYY	Last Day Worked: DD-MM-YYYY	Returned to Worked: DD-MM-YYYY
Reason for Stopping Work			
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 ________ 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: During work at area a dog attacketed me. I got injured.

Date of Accident or the date I first Noticed the symptoms of this was: 23.08.2024	(a) Is your accident or illness related to your occupation? ☑ Yes ☐ No If "Yes", Please explain: Yes because in area I was working this happend to me.
I (was/have) unable to work because of this disability starting on 23-08-2024	I (returned/was able to return/will be able to return to work on a full time basis on 25.08.2024
On What date did employer discontinue your monthly salary/wages 23-08-2024	Treated by ☑ Hospital ☐ Doctor
Date I was first treated for this accident or illness 23.08.2024	Name: Civil Hospital Address: Jinnah Road.
Have you ever had the same or Similar condition in the past? ☐ Yes ☑ No If "Yes", when	Treated by ☑ Hospital ☐ Doctor Name: BMC Address: Barori Road

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: 7-11-2024 Signature of Employee: Naila 7.11.24 Telephone No. 03330496505

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