FAMILY TAKAFUL

Pak-Qatar Family Takaful Limited

Form DS-1

Employer's Statement

Note :
Please don't leave any blank, unanswered question, date and/or signature, wherever applicable

Section I

1. Policy No. | 2. Name of Policy Holder:
3. Name of Claimant | 4. Designation
5. Phone No. | 6. Fax No. | 7. E-mail address
8. Employee's Name: Khalid Wasim | 9. CNIC No. 42201-1138677-5
10. Employee's Address: village Wanda Khawaz district Lakki Marwat
11. Employee's Date of Birth: 25-3-1987 | 12. Age: 33 years | 13. S. No. on list

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

1. Employee's Date of Appointment	2. Employee's Effective date of Takaful	3. Last day Worked	4. Returned to work on
01/02/2019	11/02/2019	31/12/2019	03/01/2020

5. Reason for Stopping Work: Due to road accident
6. Gross Earning from Salary/Wages: Rs. 50400/- Per Month | 7. Amount of Takaful Cover: Rs. 100,000/-
7. What is the present employment stats of the employee? ☑ On Duty ☐ On Sick leave ☐ Terminated ☐ Temporary laid off
8. Amount of Claim: 18,440/- | 9. Title of Cheque

Claimant Signature:
Name: | Telephone No.:
Date of statment: | Company Stamp

Section III (to be completed in Full by the Patient/Employee)

1. Type of disability claim? ☐ Natural (Sickness) ☑ Accidental
2. Please describe how and where the disability/accident occurred: Road accident while returning from duty station to home.

3. **Date of Accident** or the date I **first noticed** the symptoms of this illness was: 31/12/19 (Day/Month/Year)	4.(a) Is your accident or illness related to your occupation? ☑ Yes ☐ No if "Yes", Please explain	
5. I (was/have) unable to work because of this disability starting on: 01/1/2020 (Day/Month/Year)	6. I (returned/was able to return/will be able to return to work on a full time basis on: 03/01/20 (Day/Month/Year)	7. On what date did employer discontinue your monthly salary/wages? / / (Day/Month/Year)
8. I Date I was first treated for this accident or illness: 01/01/2020 (Day/Month/Year)	Treated by ☑ Hospital ☐ Doctor Name: City Hospital Lakki Marwat Address:	
9. Have you ever had the same or similar condition in the past? ☐ Yes ☐ No If "Yes", when	Treated by Hospital Doctor Name: Address:	

I verify that the above information is true and correct. I AUTHORIZE any doctor, medical practitioner, hospital, clinic, other medical or medically related facility or insurance company or employer having information available regarding the benefit or the diagnosis, treatment or prognosis with respect to any physical or mental condition and/or condition of me to give Pak Qatar Family Takaful Limited, or its representatives any 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: 24-01-2020 Signature of Employee: Telephone No. 03455839773

Ref No.: GT/CL/2008/00053/1