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.	Phone No / Mobile No	E-mail address
Employee's Name. Shaheen Gulam mustafa		CNIC. 5440167996656
Employee's Address		
Employee's Date of Birth Age		S. No. on list

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

Employee's Date of Appointment	Employee's Effective Date of Takaful	Last Day Worked	Returned to Worked
Reason for Stopping Work		13 Feb	10 March
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 Shaheen Gulam mustafa Telephone No 03377303915

Date of Statement _____

Employer Signature Shaheen 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 Burned while in a gas Leakage at her home - (Skin Burned)

Date of Accident or the date I first Noticed the symptoms of this was: 13-02-2025	(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 13-02-2025	
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	Treated by ☑ Hospital ☑ Doctor Name Surjeet Kumar Address Doctors hospital.
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 Autihorization will be valid as the original. this authorization will remain valid for the term of coverage of the policy

Date of Statement: 09-04-2025 Signature of Employee: Shaheen Telephone No. 03377303915