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 _____ 9. CNIC No. _____
10. Employee's Address _____
11. Employee's Date of Birth _____ 12. Age _____ 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

5. Reason for Stopping Work _____
6. Gross Earning from Salary/Wages Rs. _____ Per Month 7. Amount of Takaful Cover Rs. _____
7. What is the present employment stats of the employee? ☐ On Duty ☐ On Sick leave ☐ Terminated ☐ Temporary laid off
8. Amount of Claim _____ 9. Title of Cheque _____

Claimant Signature: [signature]
Name: Abdullah Telephone No.: 03025117663
Date of statment: 12/10/2020 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: Accident / disability occured on road while I was on Monitoring visit to field

3. **Date of Accident** or the date I **first noticed** the symptoms of this illness was: 13 / 8 / 2020 (Day Month Year)	4.(a) Is your accident or illness related to your occupation? ☑ Yes ☐ No- if "Yes", Please explain: facing trouble in driving bike	
5. I (was/have) unable to work because of this disability starting on: 13 / 8 / 2020 (Day Month Year)	6. I (returned/was able to return/will be able to return to work on a full time basis on: 20 / 9 /2020 (Day Month Year)	7. On what date did employer discontinue your monthly salary/wages? - / - / - (Day Month Year) Not discontinued
8. I Date I was first treated for this accident or illness 13 / 8 / 2020 (Day Month Year)	Treated by ☐ Hospital ☑ Doctor — Name: Dr. Nisar Ahmad — Address: New Habib Med Complex	
9. Have you ever had the same or similar condition in the past? ☐ es ☑ If "Yes", when	Treated by Hospital Doctor — Name: M. Ali Shah — Address: Hayat Complex DIC	

I certify 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 treatment of me to give Pak-Qatar Family Takaful Limited, or its representatives 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 : 12/10/20 Signature of Employee: [signature] Telephone No. 0302-5117663

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