Pak-Qatar Family Takaful Limited

FAMILY TAKAFUL

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. NIL
2. Name of Policy Holder: ~~NIL~~ Riaz Hussain
3. Name of Claimant Riaz Hussain
4. Designation UCPO
5. Phone No. 03328296812
6. Fax No. No
7. E-mail address sh636577@gmail.com
8. Employee's Name Riaz Hussain
9. CNIC No. 43204-2739014-5
10. Employee's Address Village Allah Dito Jalbani Taluka Sijawal Junejo
11. Employee's Date of Birth 20-03-1982
12. Age 38
13. S. No. on list 05

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
16/10/2016	25/01/2021	25/01/2021	+ / +

5. Reason for Stopping Work: I meet an accident and leg was fractured
6. Gross Earning from Salary/Wages: Rs. 55290 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 170530
9. Title of Cheque 0610 9950 5100 3602

Claimant Signature:
Name: Riaz Hussain
Telephone No.: 03328296812
Date of statment: 24-04-2021
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: I meet on accident while driving motorcycle on Ghasikharo road near Kot Lal Bux Mahessar

3. **Date of Accident** or the date I **first noticed** the symptoms of this illness was: 25/01/2021 (Day Month Year)

4.(a) Is your accident or illness related to your occupation? ☑ Yes ☐ No
if "Yes", Please explain: I was in field supervision

5. I (was/have) unable to work because of this disability starting on: 25/01/2021 (Day Month Year)

6. I (returned/was able to return/will be able to return to work on a full time basis on: 31/05/2021 (Day Month Year)

7. On what date did employer discontinue your monthly salary/wages? 01/03/2021 (Day Month Year)

8. I Date I was first treated for this accident or illness: 25/01/2021 (Day Month Year)

Treated by ☑ Hospital ☐ Doctor
Name: Casualty hospital Larkana then shifted to Ward ||
Address:

9. Have you ever had the same or similar condition in the past? ☐ Yes ☑ If "Yes", when

Treated by Hospital Doctor
Name: No
Address:

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: 23/05/21
Signature of Employee:
Telephone No. 03328296812

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

Pak-Qatar Family Takaful Limited

FAMILY TAKAFUL

Form DS-2

Physician's Statement

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

Patient Information

Name of Patient: Riaz Hussain — Date of Birth: 20-03-1982

Patient's Address: Village: Allah Dito Jalbani Taluka: Sijawal Junejo

Employer Information

Name of employer: Riaz Hussain

1. History

(a) Date doctor first consulted due to disability: 25 - 01 - 2021 (Day / Month / Year)

(b) Date symptoms first appeared or accident happened: 25 - 01 - 2021 (Day / Month / Year)

(c) Date patient ceased work because of disability: 25 01 - 2021 (Day / Month / Year)

(d) Has patient ever had same or similar condition? ☑ No ☐ Yes, state when and describe

(e) Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☑ No ☐ Unknown

(f) Name the first doctor with full address, consulted by the claimant for the above disability/Accident?
Dr: Zameer Hussain (Name of Doctor) Address: Larkana Mobile No. 03003407677

2. Diagnosis

(a) Date of Last examination/Consultation: 04 - 04 - 2021 (Day / Month / Year)

(b) Diagnosis (including any complications): No

(c) Subjective symptoms: Fracture in right leg

(d) Objective findings (including **current** X-rays, ECG's, laboratory data and any **clinical findings**):
(1). Clinical Findings: Fracture in right leg
(2). Diagnostic studies and results: Fracture in right leg

3. Progress

(b) Patient is ☐ Ambulatory ☐ Bed confined ☐ House confined ☑ Hospital confined

(a) Patient has ☐ Recovered ☑ Improved ☐ Stabilized ☐ Retrogressed

4. Prognosis

(a) Is the disability presumed to be reversible? ☐ Yes ☑ No

(b) Is patient now capable of performing duties of ☐ Yes ☑ No His or Her Current Jon ☐ Yes ☑ No *Any other job for which he or she is reasonably suited or qualified by education, training or experience

(c) What duties of his or her job is patient incapable of performing? — No

(d) Do you expect a fundamental or marked change in future? ☑ Yes ☐ No
If "Yes", patient should recover sufficiently to perform duties on or about 31 - 05 - 2021 (Day / Month / Year)

If "No", please explain —

(e) Specify the date by which you presume that the patient will be able to resume his duties/work:
☐ Totally ☐ Partially ☐ Temporarily ☑ Permanently 31-05-2021

Remarks

Declaration : I hereby declared that the above statements are true and complete to the best of my knowledge.

Signature	Date 23/5/21
Attending physician's name: Dr. Badaruddin Soomro	Specialty: Orthopedic
Address: Dept of orthopedic Dutta/CHK	Telephone No. 03013537350

Ref No.: GT/CL/2008/00054/1