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. | 2. Name of Policy Holder:
3. Name of Claimant: WALEED ALI | 4. Designation: UCPO
5. Phone No.: 03313623561 | 6. Fax No.: — | 7. E-mail address: Waleed_smr@Yahoo.com
8. Employee's Name: WALEED ALI | 9. CNIC No.: 4530l-8497940-9
10. Employee's Address:
11. Employee's Date of Birth: 03-02-93 | 12. Age: 29 | 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: Road Accident.
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: 6960/- | 9. Title of Cheque:

Claimant Signature:
Name: Waleed Ali | Telephone No.: 03313623561
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:

3. **Date of Accident** or the date I **first noticed** the symptoms of this illness was: 26 / 2 / 2022 (Day Month Year)

4.(a) Is your accident or illness related to your occupation? ☑ Yes ☐ No
If "Yes", Please explain: During Field got Accident.

5. I (was/have) unable to work because of this disability starting on: 26 / 2 / 22 (Day Month Year)

6. I (returned/was able to return/will be able to return to work on a full time basis on: / / (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: 26 / 2 / 22 (Day Month Year)

Treated by ☑ Hospital ☐ Doctor
Name: Faridia Hospital / Mamji Hospital / Darul Sehat — Address:

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

Treated by Hospital Doctor
Name: Dr SM Azhar - Darul Sehat Hospital — 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 :
Signature of Employee:
Telephone No. 03313623561

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: WALEED ALI	Date of Birth: 03-02-2022
	Patient's Address: Sujoni Town	
Employer Information	Name of employer: Chip Training and Consultant (CTC).	

1. History

(a) Date doctor first consulted due to disability — Day ____ Month ____ Year ____

(b) Date symptoms first appeared or accident happened — Day 26 Month 01 Year 22

(c) Date patient ceased work because of disability — 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. S.M. AZEAR (Name of Doctor) DARUSSAIHA HOSPITAL G.J. Karachi (Address) Mobile No.

2. Diagnosis

(a) Date of Last examination/Consultation — Day 26. Month 1 Year 22

(b) Diagnosis (including any complications): Wrist Pain

(c) Subjective symptoms: Wrist P.

(d) Objective findings (including **current** X-rays, ECG's, laboratory data and any **clinical findings**): Pain & Difficulty in Wrist

(1). Clinical Findings

(2). Diagnostic studies and results:

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? Rolling.

(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 — 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

Remarks

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

Signature: Dr. S.M. AZEAR	Date: 17/02/22
Attending physician's name: DR. S.M. AZEAR	Specialty: Ortho
Address: DARUSSAIHA.	Telephone No. 03365743/2

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