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: Sheraz Imran.
3. Name of Claimant: Sheraz Imran.
4. Designation: UCPO
5. Phone No. 0317-2285560
6. Fax No.
7. E-mail address
8. Employee's Name: Sheraz Imran.
9. CNIC No. 42501-668854-3
10. Employee's Address: UC-30 Yaseenabad.
11. Employee's Date of Birth: 1-1-1975
12. Age: 47
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: During field. visit.
6. Gross Earning from Salary/Wages Rs. 55,400 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: Sheraz Imran

Telephone No.:

Date of statment: 1-7-2022

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: During last NIDs MAR'22, while working on field fell down from stairs and got severed injured, survical pain and injury occured and is unable to walk properly
3. **Date of Accident** or the date I **first noticed** the symptoms of this illness was: 06 / 03 / 2022 (Day Month Year)
4.(a) Is your accident or illness related to your occupation? ☑ Yes ☐ No — if "Yes", Please explain: It was during field work, the accident occured
5. I (was/have) unable to work because of this disability starting on: 06 / 03 / 2022 (Day Month Year)
6. I (returned/was able to return/will be able to return to work on a full time basis on: 19 / 07 / 22 (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: 06 / 03 / 2022 (Day Month Year) — Treated by ☑ Hospital ☐ Doctor — Name: Patel Hospital — Address: Gulshan-e-Iqbal
9. Have you ever had the same or similar condition in the past? ☐ Yes ☑ No — If "Yes", when — Treated by Hospital Doctor — Name: — for Dr. Salman Sharif [signature] — Address

DR. SALMAN SHARIF
FRCS (LONDON) FRCS (NEUROSURGERY)
CONSULTANT SPINAL & NEUROSURGEON
Liaquat National Hospital

I certify that the above information is true and correct. I AUTHORIZE any doctor, medical practitioner, hospital, clinic, other 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 01-07-2022 Signature of Employee: [signature] Telephone No.

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

FAMILY TAKAFUL

Pak-Qatar Family Takaful Limited

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: Sheeraz	Date of Birth: 42 yrs.
	Patient's Address	
Employer Information	Name of employer	

1. History

(a) Date doctor first consulted due to disability: 30 / 6 / 22 (Day Month Year)

(b) Date symptoms first appeared or accident happened: 6 months back. (Day Month Year)

(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?

Name of Doctor: Dr. Salman Sharif Address: ____ Mobile No. ____

2. Diagnosis

(a) Date of Last examination/Consultation: 30/6/22 (Day Month Year)

(b) Diagnosis (including any complications): Cervical Disc Prolapse.

(c) Subjective symptoms: (R) upper limb weakness

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

(1). Clinical Findings: As above

(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?

(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: [signature]	Date: 01/7/22
Attending physician's name: Dr. Salman Sharif	Specialty: Neurosurgery
Address: LNH.	Telephone No.

DR. SALMAN SHARIF
FRCS(LONDON), FRCS(NEUROSURGERY)
CONSULTANT SPINAL & NEUROSURGEON
Liaquat National Hospital

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