PAK-QATAR FAMILY TAKAFUL
Together for the Future

Employer's Statement – D1 (for Death Claim)

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

1.Policy holder's information

Name of Company	
Takaful Policy No.	Policy Start Date

2.Participant's information

a. Deceased' Name: DARVAFT KHAN

b. Father's Name/ Husband's Name: NIAMAT KHAN

c. Date of Birth of deceased: 12-Jan-1976 Age: 48 CNIC No: 17201-6923239-3

d. Residential Address: Mohallah Aadhyar Khel Nowshera City

Contact No: 0314-9693052

e. Proof of age: ☑ National Identity Card ☐ Matric Certificate ☐ Other (Please specify)

3.Occupational Information

a. Employee No.

b. Date of Joining of Company: CTC 1-2-2018

c. Designation: UCPO

d. Monthly Salary: 65000

e. Occupation (at date of Death): ~~UCPO~~ UCPO

4. Event Information

a. Date of Diagnosis: 1-12-2023

b. Date of Death: 29-2-2024

c. Place of Death: Northwest Hospital

d. Primary Cause of Death: Necrotising Pancreatitis

e. Secondary cause: Sepsis

f. On what date did deceased last attend his usual work? 19-2-2024

g. When did deceased first complain of or give other indications of his/her last illness? 2 Months from death

5. Claim Information

a. Amount of Claim

b. Title of Cheque

6.Declaration by Employer/Authorized representative

The undersigned, hereby makes claim to said Takaful coverage and hereby agrees that the written statements and affidavits of all the physicians who attended to or treated the Participant shall constitute and they are hereby made a part of these proofs of death and further agrees that the furnishing of this form, or of any nor a waiver of any of its right or defenses.

Furthermore, I/We hereby authorize, any physicians, hospitals, clinic or medical service provider, insurance company, or any other institution, or any person, who has any record or information about above mentioned life to provide Pak-Qatar Family Takaful Limited complete information including copies of records with reference to any sickness, accident, disability treatment , examination, medical investigation , advise or hospitalization underwent. A photocopy of this authorization shall be as valid as the original.

Claimant Signature:

Name:

Date:

Company Stamp

Checklist

- ☐ Form D-2 Physician's Statement
- ☐ CNIC - Deceased
- ☐ Death Certificate - NADRA
- ☐ Death Certificate Hospital
- ☐ Complete past treatment record (if any)
- ☐ Attendance record of six months before death
- ☐ Salary record of six months before death
- ☐ AML Questionnaire
- ☐ Copy of FIR/Police report (in case of unnatural cause)
- ☐ Copy of Autopsy report (if any)
- ☐ Copy of Driving license (in case of accident)

Please ensure to enclosed above mentioned document in order to avoid any delay

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