PAK-QATAR FAMILY TAKAFUL
Together for the Future

Employer's Statement – Dis
(Disability Claim Form)

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

Section I.Policy holder's information

Name of Policy Holder: Anum Un Nisa.		
Takaful Policy No.	Takaful Policy Commencement Date.	
Designation: CHW	Phone No / Mobile No: 03152187926.	E-mail address: -
Employee's Name: Anum Un Nisa		CNIC: 42501-1678942-2.
Employee's Address		
Employee's Date of Birth: 2-2-2000 Age: 24	S. No. on list	

Section II (to be completed in Full by the Employer)

Employee's Date of Appointment: 3/3/2024	Employee's Effective Date of Takaful	Last Day Worked: 2/3/2024	Returned to Worked: 21/3/2024
Reason for Stopping Work: Due to head injury, back injury and injuries on elbow, hands & feet.			
Gross Earning from Salary/Wages: Rs. _____ PerMonth	Amount of Takaful cover Rs.	What is the present employment stats of the employee: ☐ On Duty ☐ On Sick Leave ☐ Terminated ☐ Temporary Laid off	
Amount of Claim	Title of Cheque		

Claimant Name _____ Telephone No _____

Date of Statement: 17-3-2024.

Employer Signature: _____ Company Stamp

Section III (to be completed in Full by the Patient/Employee)

Type of disability claim? ☐ Natural (Sickness) ☑ Accidental

Please describe how and where the disability/accident occured: while coming to TSC in Morning, Got hit by a vehicle near petrol pump.

Date of Accident or the date I first Noticed the symptoms of this was: 3/3/2024	(a) Is your accident or illness related to your occupation? ☑ Yes ☐ No if "Yes", Please explain: Iam working in fieldwork. and due to injuries Iam unable to work in field.
I (was/have) unable to work because of this disability starting on: 3/3/2024	I (returned/was able to return/will be able to return to work on a full ti- sis on: 21/3/2024.
On What date did employer discontinue your monthly salary/wages	Treated by ☑ Hospital ☑ Doctor Name: Dr. Tahir Address: Bi Hospital.
Date I was first treated for this accident or illness: 3/3/2024	Treated by ☑ Hospital ☑ Doctor Name: Address:
Have you ever had the same or Similar condition in the past? ☐ Yes ☑ No If "Yes", when	

I certify that the above information is true and correct. I AUTHORIZE any doctor, medical practioner, hospital, clinic, other medical or medically related facility or insurance company of employer have 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 respresentatives 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

QUAID MEDICAL CENTRE

Date of Statement: 17-3-2024. Signature of Employee: _____ Telephone No. 0315-2187926.

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