



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		
Takaful Policy No.	Takaful Policy Commencement Date.	
Designation: <u>A.S</u>	Phone No / Mobile No <u>0331-8097014</u>	E-mail address
Employee's Name: <u>Waheed Ahmed</u>	CNIC: <u>54303-17906767</u>	
Employee's Address: <u>Kili Saikhanzai Union Council Dabkhanzai-2 Pishin</u>		
Employee's Date of Birth: <u>10-10-1990</u> Age <u>34</u>	S. No. on list	

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

Employee's Date of Appointment: <u>01-06-2023</u>	Employee's Effective Date of Takaful: <u>12-1-2024</u>	Last Day Worked: <u>11-Mar-2024</u>	Returned to Worked
Reason for Stopping Work: <u>Accident</u>			
Gross Earning from Salary/Wages: Rs. _____ Per Month	Amount of Takaful cover: Rs. _____	What is the present employment status of the employee: <input checked="" type="checkbox"/> On Duty <input type="checkbox"/> Terminated <input type="checkbox"/> On Sick Leave <input type="checkbox"/> Temporary Laid off	
Amount of Claim	Title of Cheque		
Claimant Name	Telephone No. _____		
Date of Statement	_____		
Employer Signature: <u>[Signature]</u>	Company Stamp		

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

Type of disability claim?	<input type="checkbox"/> Natural (Sickness)	<input checked="" type="checkbox"/> Accidental
Please describe how and where the disability/accident occurred: <u>on 11-Mar-2024 when we were on EOA activity on the way accident occur.</u>		
Date of Accident or the date I first Noticed the symptoms of this was: <u>11-Mar-2024</u>	(a) Is your accident or illness related to your occupation? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No if "Yes", Please explain	
I (was/have) unable to work because of this disability starting on: <u>11-Mar-2024</u>	<u>During EOA activity accident occur</u>	
On What date did employer discontinue your monthly salary/wages	I (returned/was able to return/will be able to return to work on a full time basis on	
Date I was first treated for this accident or illness: <u>11-Mar-2024</u>	Treated by: <input type="checkbox"/> Hospital <input checked="" type="checkbox"/> Doctor	Name: <u>THQ Pishin</u> Address: <u>Pishin</u>
Have you ever had the same or Similar condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", when	Treated by: <input type="checkbox"/> Hospital <input checked="" type="checkbox"/> Doctor	Name: <u>DR. NISAR AHMED</u> Address: <u>Pishin</u>
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 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 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: <u>01-Apr-2024</u>	Signature of Employee: <u>[Signature]</u>	Telephone No. <u>0333 779204</u>

PAK-QATAR FAMILY TAKAFUL LIMITED

102-105, Business Arcade, Block-6, P.E.C.H.S, Shakra-e-Faisal, Karachi 75400, Phone: (92-21) 34311747-56 (Ext-162)
 Fax: (9221) 34386451, UAN: 021-111-TAKAFUL (825238), Email: life.claims@pakqatar.com.pk, www.pakqatar.com.pk

111-TAKAFUL (825-238)

www.pakqatar.com.pk