



Pak-Qatar Family Takaful Limited

Form DS-2

Physician's Statement

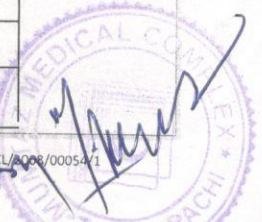
Note : Please don't leave any blank, unanswered question, date and/or signature, wherever

Patient Information	Name of Patient M. MUDASSIR GHANI	Date of Birth 20-06-1978
	Patient's Address II-D 14/12/1 NAZIMABAD KARACHI	
Employer Information	Name of employer CTC	
1. History	(a) Date doctor first consulted due to disability	<u>9</u> / <u>8</u> / <u>2021</u> Day Month Year
	(b) Date symptoms first appeared or accident happened	<u>9</u> / <u>8</u> / <u>2021</u> Day Month Year
	(c) Date patient ceased work because of disability	____ / ____ / ____ Day Month Year
	(d) Has patient ever had same or similar condition?	<input type="checkbox"/> No <input type="checkbox"/> Yes, state when and describe
	(e) Is condition due to injury or sickness arising out of patient's employment?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	(f) Name the first doctor with full address, consulted by the claimant for the above disability/Accident?	<u>Dr. Mohammad Arif</u> (Al-Muntaz Medical Complex main) K.R. Name of Doctor Address Mobile No.
2. Diagnosis	(a) Date of Last examination/Consultation	____ / ____ / ____ Day Month Year
	(b) Diagnosis (including any complications)	Undisplaced # Distal Radius
	(c) Subjective symptoms	Fracture + Undisplaced # distal Radius / POP. H/O Fall.
	(d) Objective findings (including current X-rays, ECG's, laboratory data and any clinical findings):	RS 10217/-
3. Progress	(b) Patient is	<input type="checkbox"/> Ambulatory <input type="checkbox"/> Bed confined <input type="checkbox"/> House confined <input type="checkbox"/> Hospital confined
	(a) Patient has	<input type="checkbox"/> Recovered <input type="checkbox"/> Improved <input type="checkbox"/> Stabilized <input type="checkbox"/> Retrogressed
4. Prognosis	(a) Is the disability presumed to be reversible?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(b) Is patient now capable of performing duties of	<input type="checkbox"/> Yes <input type="checkbox"/> No His or Her Current Job *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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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:	<input type="checkbox"/> Totally <input type="checkbox"/> Partially <input type="checkbox"/> Temporarily <input type="checkbox"/> Permanently

Remarks

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

Signature	Date
Attending physician's name Dr. Mohammad Arif	17-09-2021
Address Al-Muntaz medical complex Nahi Kalabarda Karachi	Specialty
	Telephone No. 3451099 34404040





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:	
3. Name of Claimant		4. Designation	
5. Phone No.		6. Fax No.	
		7. E-mail address	
8. Employee's Name	M MUDASSIR GHANI		9. CNIC No.
			421018766683
10. Employee's Address	11-D 14/12/1 NAZIMABAD KARACHI		
11. Employee's Date of Birth	20/06/1978	12. Age	42
		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			
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? <input type="checkbox"/> On Duty <input type="checkbox"/> On Sick leave <input type="checkbox"/> Terminated <input type="checkbox"/> Temporary laid off			
8. Amount of Claim		9. Title of Cheque	
Claimant Signature:			
Name:		Telephone No.:	
Date of statement:			Company Stamp

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

1. Type of disability claim? <input type="checkbox"/> Natural (Sickness) <input checked="" type="checkbox"/> 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: 08/08/2021 Day Month Year	4.(a) Is your accident or illness related to your occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No if "Yes", Please explain	
5. I (was/have) unable to work because of this disability starting on: 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 08/08/2021 Day Month Year	Treated by <input checked="" type="checkbox"/> Hospital <input type="checkbox"/> Doctor ABBASI SHAHEED HOSPITAL, NAZIMABAD KARACHI Name Address	
9. Have you ever had the same or similar condition in the past? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes", when	Treated by Hospital Doctor Name 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.