Pak-Qatar Family Takaful Limited

FAMILY TAKAFUL

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: 9 (Day) 8 (Month) 2021 (Year)

(b) Date symptoms first appeared or accident happened: 9 (Day) 8 (Month) 2021 (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?

Dr Mohammad Aarij (Al-Mumtaz Medical Complex Malir) Kr.

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**):

(1). Clinical Findings

(2). Diagnostic studies and results: Rs 10217/-

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	Date: 17-09-2021
Attending physician's name: Dr. Mohammad Aarij	Specialty
Address: Al-Mumtaz Medical Complex Malir Kalabarda Karachi	Telephone No. 3451199 3440440

MEDICAL COMPLEX KARACHI

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

Pak-Qatar Family Takaful Limited

FAMILY TAKAFUL

Form DS-1

Employer's Statement

Note :
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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.: 42101 87666683
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? ☐ On Duty ☐ On Sick leave ☐ Terminated ☐ Temporary laid off
8. Amount of Claim | 9. Title of Cheque

Claimant Signature:

Name: Telephone No.:

Date of statment: 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

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? ☐ Yes ☐ 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 ☑ Hospital ☐ Doctor ABBASI SHAHEED HOSPITAL, NAZIMABAD KARACHI Name Address	
9. Have you ever had the same or similar condition in the past? ☐ Yes ☑ 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.

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