FAMILY TAKAFUL

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: ISHTIAQUE AHMED
3. Name of Claimant: ISHTIAQUE AHMED
4. Designation: UC POLIO OFFICER
5. Phone No.: 0336-8353295
6. Fax No.
7. E-mail address: ishtiaqueahmednaich@gmail.com
8. Employee's Name: ISHTIAQUE AHMED
9. CNIC No.: 43402-0346931-5
10. Employee's Address: R-407, CITY VILLAS, SCHEME-38, UNIVERSITY ROAD KHI.
11. Employee's Date of Birth: 10-4-1987
12. Age: 35 Yrs
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: ACCIDENT
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: ISHTIAQUE AHMED

Claimant Signature:
Name: ISHTIAQUE AHMED
Telephone No.: 03368353295
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: On Dated 17th November 2022 I was returned from my Team support center, suddenly Accident Occured on Dalmia road (UC-07)

3. **Date of Accident** or the date I **first noticed** the symptoms of this illness was: 17/11/22 (Day Month Year)

4.(a) Is your accident or illness related to your occupation? ☑ Yes ☐ No
if "Yes", Please explain: I was returned from Team supporting center suddenly accident Occured on Dalmia road.

5. I (was/have) unable to work because of this disability starting on: 17/11/22 (Day Month Year)

6. I (returned/was able to return/will be able to return to work on a full time basis on: 05/12/22 (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: 17/11/22 (Day Month Year)

Treated by ☑ Hospital ☐ Doctor
Name: BURHANI HOSPITAL, PAKISTAN CHOWK
Address: Saddar KHI

9. Have you ever had the same or similar condition in the past? ☐ Yes ☐ 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: [signature]

03368353295
Telephone No.

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

Pak-Qatar Family Takaful Limited

Form DS-2

Physician's Statement

Note :
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Patient Information

Name of Patient: Ishtiaque Ahmed
Date of Birth:
Patient's Address: R-407 City Villas Scheme 33 Karachi.

Employer Information

Name of employer:

1. History

(a) Date doctor first consulted due to disability: 18 (Day) 11 (Month) 22 (Year)

(b) Date symptoms first appeared or accident happened: 17 (Day) 11 (Month) 22 (Year)

(c) Date patient ceased work because of disability: 17 (Day) 11 (Month) 22 (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?
Name of Doctor: Dileep Kumar, Address: Burhani Hospital Karachi, Mobile No.: 0333-2329285

2. Diagnosis

(a) Date of Last examination/Consultation: 05 (Day) 12 (Month) 22 (Year)

(b) Diagnosis (including any complications): Fracture left elbow

(c) Subjective symptoms: Pain, Swelling, Difficulty in Moving elbow

(d) Objective findings (including current X-rays, ECG's, laboratory data and any clinical findings):
(1). Clinical Findings: Swelling, Tenderness, effects & Painful elbow Movement
(2). Diagnostic studies and results: X-ray, Blood tests.

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: 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 ☐ Yes ☐ No

(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: 20 (Day) 01 (Month) 2023 (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: [signature]	Date: 13.12.2022
Attending physician's name: Dileep Kumar	Specialty: Orthopedic Surgery.
Address: Burhani Hospital, Karachi.	Telephone No.: 0333-2329285

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