Employer's Statement – DS1
(Disability Claim Form)

PAK-QATAR FAMILY TAKAFUL

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.	Phone No / Mobile No	E-mail address
Employee's Name.		CNIC.
Employee's Address		
Employee's Date of Birth Age		S. No. on list

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

Employee's Date of Appointment DD-MM-YYYY	Employee's Effective Date of Takaful DD-MM-YYYY	Last Day Worked DD-MM-YYYY	Returned to Worked DD-MM-YYYY
Reason for Stopping Work			
Gross Earning from Salary/Wages Rs._____ PerMonth	Amout 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 _____

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 _____

Date of Accident or the date I first Noticed the symptoms of this was: DD-MM-YYYY	(a) Is your accident or illness related to your occupation? ☐ Yes ☐ No if "Yes", Please explain
I (was/have) unable to work because of this disability starting on DD-MM-YYYY	I (returned/was able to return/will be able to return to work on a full time basis on DD-MM-YYYY
On What date did employer discontinue your monthly salary/wages DD-MM-YYYY	Treated by ☐ Hospital ☐ Doctor Name Address
Date I was first treated for this accident or illness DD-MM-YYYY	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 confition 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 Autihorization 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.

Pak-Qatar Family Takaful Limited (PQFTL)

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