

PERSONAL ACCIDENT DEATH - CLAIM FORM

(The company does not warrant admission of liability by the issuance of this form)

Policy No					Claim No	
The MEDICAL CERTIFIC	CATE OVERLEAF is to be furnished at	t the expense	of the part	ticipant.		
Full Name						
Residence Address					Telephone No	
Date of Birth		CNIC	[
Business Address					Occupation	
Present Business & Occupation (If more than one State all)						
Required in case of Accie	dental Disability)					
Date, time and place of a	ccident / Injury					
Give particulars of the ca	use,and the injuries sustained					
Names and addresses of	any Witnesses of the accident (if any)					
Name and address of the	e Doctor attending the patient					
State where and when a Company can visit you, if	Medical or other officer of the necessary.					
disabled from attending to result of the accident.(b)	which you or patient have been totally o your business as the sole and direct Are you still totally disabled? If not, able to attend to some part of your					
Are you still totally disable able to attend tosome pa	ed? If not, from what date were you rt of your business?					
	usly claimed or received compensatior r Sickness Policy? If so, please give	1				
Are you/patient covered	from elsewhere?					
If so, give the name of ea to claim.	ch Company , and amount entitled					
Date, time and place of a	ccident / Injury /					
Give particulars of the ca	use				 	
Brief description of occur	rrence of accident					

Name and address of Hospital & Doctor attended the patient	
Did police investigated the incident? If yes, please provide the name of police station & investigation officer.	Yes No
Did post mortem take place? If yes, please provide the copy of report	Yes No

P.S.The MEDICAL CERTIFICATE from the attending physician is to be furnished at the expense of theparticipant/beneficiary/claimant.

I, the undersigned, do hereby declare that, to the best of my knowledge and belief, the foregoing particulars are true and correct.

I authorize any insurance/Takaful company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the deceased to release any information requested regarding this claim and the loss reported. I understand this information will be used by the Pak Qatar General Takaful, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim.

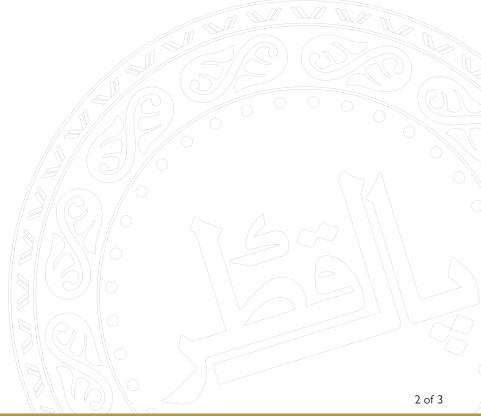
I understand that any person who knowingly and with intent to defraud or deceive any insurance/Takaful company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for fraud.

Name& Relation with Participant

(In case the claimant is different from Participant):

Contact No:	

Signature & Date : _____



MEDICAL CERTIFICATE TO BE COMPLETED BY It is understood that this certificate will be com of your existingknowledge and without unde examination.	npleted on the basis
I CERTIFY that	
was injured/dead due to accident on	
with having injuries	
ACCIDENTAL DISABILITY	
ACCIDENTAL DISABILITY He is solely and directly totally disabled on a result of the injuries ar ACCIDENTAL DEATH	nd will be so disable until
He is solely and directly totally disabled on a result of the injuries ar	
He is solely and directly totally disabled on a result of the injuries ar ACCIDENTAL DEATH	
He is solely and directly totally disabled on a result of the injuries ar ACCIDENTAL DEATH He could not sustained injuries on	

Total disablement occurs when the PARTICIPANTis wholly prevented from attending to his business or occupation.

Address: Suite # 402- 404, Business Arcade, P.E.C.H.S. Block 6, Sharah-e-Faisal, Karachi Phone: (0092) 21- 34380357-61, Fax: (0092) 21 – 34386453