PAK-QATAR
GENERAL TAKAFUL
Together We Protect

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 CERTIFICATE OVERLEAF is to be furnished at the expense of the participant.			
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 Accidental Disability)	
Date, time and place of accident / Injury	
Give particulars of the cause,and the injuries sustained	
Names and addresses of any Witnesses of the accident (if any)	
Name and address of the Doctor attending the patient	
State where and when a Medical or other officer of the Company can visit you, if necessary.	
State the period during which you or patient have been totally disabled from attending to your business as the sole and direct result of the accident.(b) Are you still totally disabled? If not, from what date were you able to attend to some part of your business?	
Are you still totally disabled? If not, from what date were you able to attend tosome part of your business?	
Have you/patient previously claimed or received compensation under an Accident and/or Sickness Policy? If so, please give particulars.	
Are you/patient covered from elsewhere?	
If so, give the name of each Company , and amount entitled to claim.	
Date, time and place of accident / Injury /	
Give particulars of the cause	
Brief description of occurrence 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: ______________________________

CNIC : ☐☐☐☐☐ – ☐☐☐☐☐☐☐ – ☐

Signature & Date : ______________________

PRIVATE AND CONFIDENTIAL

MEDICAL CERTIFICATE TO BE COMPLETED BY PARTICIPANT'S DOCTOR

It is understood that this certificate will be completed on the basis of your existingknowledge and without undertaking any future examination.

I CERTIFY that ____

was injured/dead due to accident on ____

with having injuries ________________________________

____________________.

ACCIDENTAL DISABILITY

He is solely and directly totally disabled on a result of the injuries and will be so disable until ________

____

ACCIDENTAL DEATH

He could not sustained injuries on ____________________________ and could not survive

to his life.

Name & Qualification: ____________________

____

Siganture

Hospital Name & Stamp: ____________________

Date: ________________

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