DAWOOD FAMILY TAKAFUL LIMITED
1701-A, Saima Trade Towers, I.I. Chundrigar Road, Karachi-74000
UAN: 111-DFT-786 (111-338-786) Fax: (92-21) 3227-7188
www.dawoodtakaful.com

GROUP SCHEME – DEATH CLAIM

[TO BE COMPLETED BY THE PARTICIPANT]

Please read Instructions overleaf before completing this form

Employer/Employee Group

Claim No. _____

Policy No. _____

Participant Name. _____

1	[a]	Deceased's Full Name [Block Letters]						
	[b]	CNIC Number						
	[c]	Father's Name						
	[d]	Residential Address at Death						
2	[a]	Reference of Employee's List			Original List	Page #	Serial #	
	[b]	Employment Number			Subsequent List			
3	[a]	Designation		[b]	Salary	Rs.		
4	[a]	Date of Appointment		[b]	Date of Birth/Year			
	[c]	Date of Confirmation		[d]	Age at Death			
5	[a]	Date on which the deceased last attended duty		[b]	Cause of absence thereafter			

6	[a]	Give details of leave of absence, disablement leave or temporary layoff during the 12 months preceding his/her death		
		From	To	Nature of Leave/ Lay Off Etc.
	[b]	Whether such absence was Notified to the DFTL? If so please give reference		

7	[a]	Date of Death	[b]	Time & Place of Death	[c]	Exact Cause of Death	[d]	Place of Burial

8	If the death was caused by accident, please state			
	Time & Place of Accident		How accident Occurred?	
9	[a] Amount of Sum Covered	Rs.	[b] Whether the contribution in respect of the deceased has been paid?	Yes ☐ No ☐

10	Name, Address, age & Relationship of the beneficiary of the deceased, if applicable				
	Name	Address	Age	Relationship	Contact #

The undersigned who has been duly authorized to sign for and on behalf of the participant does hereby warrant that the statements made herein are true:

Date : _____

(Affix Rubber Stamps)

_____
Authorized signature on behalf of Participant

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PHYSICIAN'S STATEMENT

To be completed by Physician

Part-I Personal Data of Deceased		
1	Deceased's Full Name (IN BLOCK)	
2	CNIC #	
3	Father's Name	
4	Residential Address at the time of Death	

PART-II Observations & Report of the Physician		
1	How long you know the deceased?	
2	Date, Time & Place of death	
3	Give exact cause of death	

Signed at _____ this _____ day of _____ 20_____

_____
Signature & Seal of the PHYSICIAN
Full Name, Address & Registration No.