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

Policy No. _____

Name of Participant : _____ Claim No._____

GROUP CLAIM BY ACCIDENT

(To be Completed by Employer/ Participant)

I Details of the Employee

1	Name (In Blocks)	
2	Address with contact No.	
3	Date of appointment of the covered person	
4	Occupation of the covered person	
5	Last Salary drawn	
6	Day(s) of Leave availed	
7	Reason(s) of Leave	

II Declaration by the Authorized person of the Company:

I,_____ employer of the below named person covered _____do hereby solemnly declare that all foregoing answers and information stated above are complete and true to the best of my knowledge and belief and I have not concealed any details from this company, which are necessary with regards to the above. I hereby declare that he/she is suffering from total and Permanent Disability and unable to follow his/her own occupation or any other occupation reasonably suited to him/her as per his/her education and experience.

Signed at_____ this _____ day of _____20_____

Signature of the Employer

Address: _____

_____

Policy No. _____

Name of Participant : _____ Claim No. _____

GROUP CLAIM BY ACCIDENT

(To be Completed by Employee / Member)

1	Name (In Blocks)						
2	CNIC						
2	Father's Name						
3	Designation						
4	Nature of Duty						
5	Working hours on the day of Accident	From: AM/PM	To: AM/PM				
6	Time and date of Accident	Time: AM/PM	Date:				
7	Where and how did the accident occur? Give full description.						
8	Give Name & Address of Eye Witness						
9	Describe fully the injuries (Enclose X-Rays and other reports)						
10	Give the name and address of the physician / surgeon who first attended you						
11	Are you still under his/her care? If not give particulars of the doctor in attendance.						
12	On what date did you stop performing all your occupational duties?						
13	On what date did you resume part of your occupational duties?						
14	Are you entitled to receive compensation for this accident under?	a) Workmen Compensation Act	Yes		No		
		b) Social Security Ordinance	Yes		No		
		If so have claimed or received compensation?	Yes		No		

Signed at _____ this _____ day of _____ 20_____

Signature of the Employee

Address: _____

_____

PTD(A)-02

GROUP CLAIM BY ACCIDENT

(To be Completed by Surgeon)

1	Name of Accidentee (In Blocks)			
2	Date & Time of Accident	Date: Time:		
3	Date of first Treatment			
4	Subsequent Treatment Dates	Hospital:	His/ Her Home	My Clinic
5	Please give full and accurate description of his/her injuries			
6	If fracture occurred, please state if compound, complete or incomplete			
7	If fracture of long bones occurred, please whether through head or shaft			
8	If dislocation occurred, please state complete or incomplete			
9	was any operation performed: if so please state describe fully			
10	Has he/ she ever suffered from any constitutional disease or physical impairment			
11	How long he/ she was totally disable and unable to perform ANY and EVERY kind of duty pertaining to his/ her occupation?			
12	How long was he/ she PARTIALLY disabled and unable to perform part of his/ her daily duties	FROM: TO:		
13	Is he/ she confined to hospital? If so, please give name of the hospital & dates of confinement.	FROM: TO:		
14	If impairment of function or deformity resulted from injury, please state fully	HOSPITAL'S NAME FROM: TO:		
15	If still totally disabled, when will it probably terminate?			

Signed at_____ this _____ day of _____ 20_____

Signature and Seal of the Surgeon
Full Name, Address and Registration No._____

PTD(A)-03

Accidental Disability Claim Requirement:

CLAIM FORMS

- ❑ **ACCIDENTAL CLAIM FORM:**
  Ensure that all the required information is provided and it is signed by the employer/ authorized officer

- ❑ **ATTENDING SURGEON'S STATEMENT**
  This form is to be filled-in by last attending physician / clinic / hospital of the accidentee

- ❑ **EMPLOYEE STATEMENT**
  This form is to be filled-in by employee himself in the event of accident, mention of date & time of accident, with witness is necessary

OTHER REQUIREMENTS

- X-rays, medical investigations reports
- An attested photocopy of CNIC
- Age proof
- A photocopy of application from
- Proof of admission and discharge in hospital with bills