DAWOOD FAMILY TAKAFUL LIMITED

1701-A Saima Trade Tower, I.I.Chundrigar Road, Karachi-74000
UAN: 111-DFT-786 (111-338-786) Fax (92-21) 3227-7188
E-mail: contactus@dawoodtakaful.com www.dawoodtakaful.com

Hospitalization Cash Rider

To Be Completed by Participant

CERTIFICATE NO.: _____ CLAIM NUMBER: _____

NAME OF PARTICIPANT: _____

1. Participant / Covered Person's Details

1) Identity Card No. (NIC): | | | | | | - | | | | | | | | - | |

2) Date of Birth: D D M M Y E A R

3)	Address	
4)	Contact No	
5)	Employer Name	
6)	Occupation	
7)	Current Salary / Earned Income	
8)	Account Title	
9)	Account IBAN	

2. HCR Details

1)	Name of Disease	
2)	Date of Diagnosis	
3)	Name of Doctor / Hospital	
4)	Date of Onset of Symptoms	
5)	Date of Admission (DOA)	
6)	Date of Discharge (DOD)	

3. In case of Surgery

1)	Date & Time of surgery	
2)	Place of surgery	
3)	Doctor who performed surgery	
4)	Reason for surgery	

3. Declaration by the Participant

I, _____, as the Participant/Claimant do hereby declare that all the foregoing answers and information stated above are complete and true to the best of my knowledge and belief and I have not concealed any important details from the Company. I hereby claim Critical Illness benefit and authorize the attending doctor(s) indicated by the doctors treating me and all documents provided to support this claim to provide Company with any information concerning my illness and treatment. I also authorize any insurance company, hospital, or organization to disclose to the Company any information or documents necessary or vital regards to the diagnosed person. I hereby declare that I am suffering from covered Critical Illness as mentioned above.

Signature of Participant: _____
Date: _____
Place: _____

Signature of Witness: _____
Name: _____
Address: _____

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Hospitalization Cash Rider

To Be Completed by Surgeon

1. Medical Attendant Details

1)	Name of Doctor	
2)	Name of Hospital with Address	
3)	Specialty	
4)	PMDC No	
5)	**Contact No**	
6)	Email	
7)	Is the covered person related to you? If yes, please give details	
8)	Date of First Visit and detail of complaints	
9)	Diagnosis Details	
10)	Cause of Disability?	
11)	Date of Admission (DOA)	
12)	Date of Discharge (DOD)	

2. Other Information

1)	Name and address of any other Doctor who attended the participant	
2)	Past history of the disease	
3)	Since how long participant was suffering from the disease	
4)	Please specify any other information which is pertinent	
5)	Detail of Complaints, Investigations, and treatment during last 5 years	
6)	In your opinion, is disability serious enough to be total and permanent?	

3. Declaration by the Medical Attendant

I, _____, medical attendant of the below-named person, do hereby solemnly declare.

Signature of Doctor with Stamp: _____ Signature of Witness: _____

Place: _____ Address: _____

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Hospitalization Cash Rider

To Be Completed by Employer

1. Details of the Employer

1)	Name of the Employer	
2)	Address of Employer	
3)	Name of the Covered Person	
4)	Date of Appointment of Covered Person	
5)	Last Salary Drawn	
6)	Days of Leave availed	
7)	Reason(s) of Leave	

2. Declaration by the Authorized Person of the Company

I, _____, employer of the below-named person, do hereby solemnly declare...

Authorized Signatory: _____

Signature of Witness: _____

Date: _____ Place: _____

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Hospitalization Cash Rider (HCR) Claim Requirement

HCR CLAIM FORM:

Ensure that all the required information is provided and it is signed by the participant / covered person.

ATTENDING SURGEON'S STATEMENT

This form is to be filled-in by the last attending physician/clinic/hospital of the accident / hospital of the illness.

EMPLOYEE STATEMENT

This form is to be filled-in by the employee himself in the event of an accident or illness, mentioning the date & time of the accident or illness. A witness is necessary.

NECESSARY REQUIREMENTS

- X-rays, medical investigations reports
- A photocopy of CNIC
- Proof of admission and discharge summary from hospital with bills
- Proof of emergency treatment (if any)
- All the Lab reports and patient history.