DFT
DAWOOD FAMILY TAKAFUL

GROUP TAKAFUL CLAIM BY NATURAL DISABILITY

(To be completed by the employee)

Claim #_____

Certificate # _____

1. Name in Full
   (In Block Letters)_____

2. Designation _____Nature of Duties_____

3. Give full description of Disability _____

4. When did you report the sickness
   which resulted in total and permanent disability _____
   _____

5. Describe fully the history of sickness
   (enclose X-ray and such other reports
   That have bearing on this claim) _____
   _____

6. Give name and address of the physician
   /Surgeon who first attended you _____
   _____

7. Are you still under his care?
   If not give particulars of the
   Doctor now in attendance? _____
   _____

8. On what date did you stop
   performing all your (Occupational) duties? _____
   _____

9. a) Are you permanently and totally disabled? _____
   b) If Yes from what date? _____

10. a) Have you been retired from services on account of disability? _____
    _____
    b) If Yes from what date? _____

Date _____ _____

Signature of the Employee

ND-01

DFT DAWOOD FAMILY TAKAFUL

GROUP TAKAFUL CLAIM BY NATURAL DISABILITY

(To be completed by the employer)

Claim #_____

Certificate # _____

11. Name in Full
    (In Block Letters)_____
12. Age _____Date of Appointment _____
13. Designation _____Salary / Wages _____
14. Quote Reference of serial page No.
    of the list of Employees as supplied to DFTL. _____
15. a) Are you satisfied that the employee's
    statement made here in (From attached) is correct? _____
    _____

    b) If not please state the inaccuracies_____
16. Please give the approximate description
    of onset of the disease / ailment which culminated
    in the disability of the employee. _____
    _____
17. When did he stop functioning/ working on
    full time basis as a consequence of the disability? _____
    _____
18. a) Is the employees being retired permanently
    because of the disability? Give Date _____

    b) If not, why_____
19. Amount of coverage _____
20. Whether contribution in respect of this employee has been paid? _____
    _____

Dated _____ _____

Signature and seal of the Employer

ND-02

DFT
DAWOOD FAMILY TAKAFUL

DFT
DAWOOD FAMILY TAKAFUL

GROUP TAKAFUL CLAIM BY NATURAL DISABILITY

(To be completed by the Surgeon/ Physician)

Claim #_____

Certificate # _____

1. Name of Disabled Person
   (In Block Letters)_____

2. Date of Disability _____Date of First Treatment _____

3. Subsequent Treatment Dates _____

Hospital	His / Her Home	My Clinic

4. Please give full and accurate description of his/her disease? _____
   _____

5. Was any operation performed:
   If so please state describe fully _____
   _____

6. Has he / she ever suffered from any
   constitutional disease or physical impairment _____
   _____

7. How long he/she was totally disable and unable to perform any kind of duty pertaining to his / her or any occupation FROM _____TO: _____

8. Is he / she confined to hospital?
   If so please give Name of the Hospital: _____
   Date of Confinement FROM: _____TO: _____

9. If impairment of function of deformity
   resulted from injury, please state fully _____
   _____

10. If still totally disabled, when will it probably terminated? _____
    _____

Dated _____ _____

Signature and seal of the Surgeon/ Physician
Full Name, Address & Registration No.

DFT DAWOOD FAMILY TAKAFUL

NATURAL DISABILITY CLAIMS REQUIREMENTS

CLAIMS FORMS

- **ND Claim Form**
  Ensure that all the required information is provided and it is signed by the employer/authorized officer

- **Attendance Surgeon's Statement**
  This from is to be filled-in by last attending physician / clinic / hospital of the employee

- **Employee Statement**
  This from is to be filled-in by employee himself

OTHER REQUIREMENTS

- X-rays, medical investigations reports
- An attested photocopy of CNIC
- Age Proof
- A photocopy of application from
- Retirement letter
- A photocopy of medical board Certificate