Pak-Qatar Family Takaful Limited

Head Office: 102-105, Business Arcade, Block 6, P.E.C.H.S.,
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Phone (92-21) 4311747-56, Fax (92-21) 4386451

Group HEALTH FAMILY TAKAFUL

Hospitalization Reimbursement Claim Form

Part A

☑ To be completed by the covered Individual Member only
☑ Do not leave any field blank, questions unanswered, or declaration undated or unsigned (wherever applicable).

Type of Claim: ☐ Pre-hospitalization expenses ☐ Hospitalization/Day Care expenses ☐ Post Hospitalization expenses
☐ Pre-natal expenses ☐ Delivery expenses ☐ Post-natal expenses

Claimant Name:	
Plan Number:	**Participant (Employer) Name:**
Plan Start Date:	**Plan End Date:**

Patient's Name:	
Patient's Takaful Certificate Number:	**Patient's Gender** ☐ Male ☐ Female
Date of Birth: ☐☐/☐☐/☐☐☐☐	**CNIC Number:** ☐☐☐☐☐-☐☐☐☐☐☐☐-☐
Contact Address:	
Phone Residence:	**Phone Office:** **Mobile:**

1. State the nature of the medical condition, injury, illness:

2. On what date did the symptoms first occur? ☐☐/☐☐/☐☐☐☐

3. Name and address of Physician provider first consulted due to above-mentioned medical condition:

4. Has the patient consulted any doctor for the above-mentioned medical condition? ☐ Yes ☐ No
If "Yes", for each doctor and hospital consulted, state name, date of consultation, reason for consultation and treatment provided.

Name of Doctor/Hospital	Date of Consultation	Reason for Consultation	Treatment/Results

5. Is this claim related to an accident? ☐ Yes ☐ No If "Yes", what was the date of the accident? ☐☐/☐☐/☐☐☐☐

Give brief detail of where and how accident occurred?

6. GIVE DETAILS OF ANY OTHER HEALTH, MEDICAL OR TRAVEL TAKAFUL / INSURANCE, WORKMAN'S COMPENSATION, SOCIAL SECURITY OR OTHER MEDICAL BENEFITS TO WHICH THE PATIENT MAY BE ENTITLED:

Name of Hospital, where treatment availed:		
Date of Admission:	**Date of Discharge:**	**Total Nos. of days**
Total amount of Claim (In Pak Rupees):		

DECLARATION & AUTHORIZATION

I hereby certify that all answers to questions appearing on this form and documents submitted with this form are true and complete to the best of my knowledge and belief.
I, the above claimant, hereby authorize any doctor, hospital, clinic or medical service provider, takaful/insurance company, or any other institution, or any person, who has any information or record about me and/or any of my dependents to provide **Pak-Qatar Family Takaful Limited** with the complete information including copies of their records with reference to any sickness, accident, disability, any treatment, examination, medical investigation, advice of healthcare provider. Photocopy of this authorization shall be valid as the original.

Date of Statement: ☐☐/☐☐/☐☐☐☐

Signature of claimant Individual Member
Employee will complete and sign this form on behalf of minor child

VERIFICATION BY PARTICIPANT/EMPLOYER

I/We hereby certify that all answers to questions appearing on this form are true and complete to the best of my/our knowledge and belief. We understand and agree that the above statement shall form the basis for Takaful coverage.

Date of Statement: ☐☐/☐☐/☐☐☐☐

Signature of Participant

Part **B**

Hospitalization Reimbursement Claim Form

☑ To be completed by the **Treating Physician.**

☑ Do not leave any field blank, questions unanswered, or declaration undated or unsigned (wherever applicable).

Patient's Name:	
Father's/Husband's Name:	**Gender** ☐ Male ☐ Female
Date of Birth: ☐☐/☐☐/☐☐☐☐	**CNIC Number:** ☐☐☐☐☐☐☐☐☐☐☐☐☐

1. How long have you been the patient's doctor?	
2. On what date were you first consulted for the injury, illness or medical condition concerned or for any related condition?	☐☐/☐☐/☐☐☐☐
3. Please give your diagnosis of the injury/illness/condition?	
4. Have you any reason to believe that the same or any related condition has been diagnosed or treated previously by any other doctor or hospital?	

5. Has the patient consulted any doctor for the above-mentioned medical condition? ☐Yes ☐No

If "Yes", for each doctor and hospital consulted, state name, date of consultation, reason for consultation and treatment provided.

Name of Doctor/Hospital	Date of Consultation	Reason for Consultation	Treatment/Results

6. Please give details of the treatment given or prescribed?	

For Maternity claim only

1. Duration of Pregnancy? ☐1st Trimester ☐2nd Trimester ☐3rd Trimester ____ weeks

2. Would normal delivery endanger the life of mother and/or child(ren) and intra-abdominal surgery necessary for extra uterine pregnancy or complications: ☐Yes ☐No
   if "Yes", please give reason in detail:

3. Is there any permicious vomiting in pregnancy, toxemia with convulsions or spontaneous abortion? ☐Yes ☐No
   if "Yes", please give reason in detail:

DECLARATION

I/We hereby certify that all answers to questions appearing on this form are true and complete to the best of my/our knowledge and belief.

Date of Statement: ☐☐/☐☐/☐☐☐☐

Signature of treating physician

Name of Physician	PMDC No.:
Address:	Contact No.:

IMPORTANT: In order to avoid any delay, please ensure that:

- ☑ Use a New Claim Form for each claim or course of treatment.
- ☑ The **Individual Covered** or his/her legal representatives must complete all questions of Part A of the claim form and sign it.
- ☑ **The treating physician** must complete all questions of Part B of the claim form and sign it.
- ☑ Please recheck and send fully completed claim form with all relevant document(s)/Report to Pak-Qatar Family Takaful Limited.
- ☑ Please be informed that;
  - o Incomplete claim form **CANNOT** be accepted for processing of payment.
  - o Ensure to attach **ORIGINALS** of all relevant document(s)/Report.
  - o Ensure to attach **ORIGINAL** bills and receipts of payment(s).
  - o **PHOTOCOPIES** are not acceptable for processing of claim.