CLAIM FORM

Important Instructions: (Please read carefully)

1. In order for us to provide fast and efficient services, kindly complete the form accurately in CAPITAL LETTERS. Photocopies of this form can also be re-produced.
2. Completed forms should be sent within 30 days of the expense incurred date to: **Health Division, Takaful Pakistan Limited, Business Centre, 6th Floor, Block 6, PECHS, Shahrah E Faisal, Karachi**.
3. Please attach the following documents with the form:
   a. Original itemized bill and original payment receipts, these should be issued on the official bill/receipt book of the hospital/Pharmacy/laboratory.

Hospital Bill should mention type of accommodation/room and breakup of total bill as per below:			
Room Charges per day	Lab Tests/Radiology Charges	Doctor visits fees	Surgeon fees
Operation Theatre Charges	Anesthesia Charges	Medicines used during hospitalization	Other miscellaneous expenses
Blood & oxygen charges			

4. Laboratory, radiology, ultrasound reports along with Doctor Prescriptions for the same.
5. Itemized, dated, bills of the medicines purchased, supported by Consultant prescriptions specifying quantity and respective dosage.
6. Hospital Discharge summary / card (in case of hospitalization)
7. Copy of Birth certificate (in case of delivery / child birth)
8. Copy of death certificate, if any.
9. Copy of CNIC and Health Card

TO BE COMPLETED BY THE EMPLOYEE / PATIENT:

Name of Employer		Policy Number	
Name of Employee		Health ID #	
Name of Patient		Total Amount Claimed (RS.)	
Date of Birth		Relationship with Employee	
Diagnosis/treatment		Duration of Illness/injury	
Date of Admission		Date of Discharge	
Contact Number/Email		CNIC Number	

Is the patient entitled to any other benefit or compensation from any other source whatsoever? If so, name the company or the association, or source, and give the amount of benefit payable by each:

DECLARATION BY THE EMPLOYEE / PATIENT:

I, hereby certify, that all answers, and all documents submitted with this form are complete and true to the best of my knowledge and belief.

I, hereby, authorize any Doctor, Hospital, clinic, or medical provider, any insurance/Takaful company, or any company, institution, or any other person who has any record or information about me and/or of my family members to provide Takaful Pakistan Limited with the information, including copies of their records with reference to any sickness or accident, any treatment, examination, advice, or hospitalization. Any photocopy of this declaration/authorization shall be taken as the original copy.

_____	_____	_____
Signature of Patient / Employee	Signature & Stamp of Employer	Date

TO BE COMPLETED BY THE ATTENDING PHYSICIAN / HOSPITAL:

Patient Name:

Primary Diagnosis | Secondary Diagnosis

When did the symptoms first appear? Day | Month | Year

When did the patient first consult for this complaint? Day | Month | Year

Has the patient ever suffered from/been treated for the same or related condition? If yes, please provide details with dates:

In case of Hospitalization:

Name/ Address of the Hospital:

Phone Number / E mail:

Hospital Admission Date: | Discharge Date:

Emergency / Elective Treatment?

Details of Surgical, Gynecological or Obstetrical procedure performed, (if any):

Type of Anesthesia Used (Tick) (LOCAL / GENERAL)

Is further treatment anticipated? (Yes / No) (If Yes, _____)

I, hereby certify that my answers to the foregoing questions are correct and true, to the best of my knowledge and belief.

Signature / stamp of Attending Doctor	
Name & Address	
Phone Number & Email Address	
Credentials/Qualifications	
Date	

For Takaful Pakistan Ltd. Use Only			
Policy Number		Emp. Health ID	
Claim Number		Claim Entered By	
Claim Received Date		Cheque Number	
Claim Approved Date		Cheque Dispatch Date	