TPLLife
Window Takaful Operations
Formerly Dar-Es-Salaam Textile Mills Ltd.

## CLAIM FORM - CRITICAL ILLNESS

1-This Form contains three (3) Sections. Each section should be filled separately by **Participant, Medical Attendant & Employer.** This form should be filled by the **Participant/Claimant** under Critical Illness Claim.
2-All persons are required to give correct & complete information. The Company is entitled not to entertain any claim if this claim form is not completed in full & accurately.
3-Acceptance of this form does not mean admission of liability by the Company.

## PART 1 – POLICY HOLDER / PARTICIPANT'S STATEMENT

**1. Covered Person's / Participant's Details**

a) Name of Covered Person / Participant_____

b) Identity Card No CNIC #

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | |

c) Date of Birth | | | | | | | | | d) Age _____ e) Sex **M** ☐ **F** ☐

f) Occupation _____

g) Address _____

h) Telephone # _____ j) Bank Account No. Name & Branch _____

_____

**2. Critical Illness Details**

a) Name of Disease _____ b) Date of Diagnosis _____

b) Hospital Name _____ d) Name of Doctor _____

e) Date of Onset of Symptoms _____ f) Date of Onset of Disease_____ g) Age at Onset _____

h) Date(s) of Confinement at Home

| Date From | Date To | Treatment Provided |
|---|---|---|
| | | |
| | | |
| | | |

k) Date(s) of Confinement at Hospital

| Hospital Name | Date From | Date To | Treatment Provided |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**3. In Case of Surgery**

a) Place of Surgery / Hospital Date & Time

| Hospital Name | Dr. Name | Date From | Date To | Reason of Surgery |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**4. Declaration by the Policy Holder / Participant's**

I _____ as the Policy Holder / Participant/Claimant do hereby declare that all foregoing answers & information stated above are complete and true to the best of my knowledge & belief & I have not concealed any important details from this Company. I hereby claim Critical Illness benefits & agree that all information disclosed by the Doctors treating me & all documents provided to support this claim is proof of it. Further, I agree that this form & other additional related documents & investigations or examinations by the Company cannot be interpreted or assumed as admission of liability by the Company, & is not proof of any agreement which takes effect on the said person or discharge of any right or defense by the Company. I hereby give consent to doctors or related parties of hospitals etc to disclose to the Company any explanation or information which is deemed necessary with regards to the diagnosed person. I hereby declare that I am suffering from covered Critical Illness as mentioned above.

_____
**Signature of Policy Holder /Participant**
Date : _____

Place :_____

_____
**Signature of Witness**
Name : _____

Address _____

Please attach the original documents of the following.

- Copy of CNIC of Claimant
- Medical History / Record
- Doctor Advice
- Hospitalization Record
- Hospital Discharge Certificate / Summary
- Prescriptions

**TPL LIFE INSURANCE LTD.**

**Window Takaful Operations**

**19-B, Lane 3, SMCHS,**

**In the lane of Roomi Masjid**

**Shahrah-e-Faisal, Karachi, Pakistan.**

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**PART 2 – MEDICAL ATTENDANCE STATEMENT**

1. **Medical Attendant Detail**

a) Name of Doctor _____

b) Name of Hospital / Address _____/_____

c) PMDC NO. _____

d) Specialty _____ e) Telephone No _____

f) Is person Covered related to you ? If yes, please give details _____

g) Date of First Visit & details of complaints _____

_____

h) Date of Last Visit _____ i) Diagnosis _____

_____

i) Cause of Disability _____

**2. Other Information**

a) Past history of the disease _____

b) Since how long deceased was suffering from the disease _____

c) Please specify any other information which is pertinent _____

d) Details of Complaints, Investigation & treatment during last 3 years _____

_____

e) In your opinion, is disability suffered considered to be total and permanent nature and preventing the person covered from ever again following his/her own occupation or any occupation which he/she is reasonably suited by reason of education, training or experience, and which has persisted for at least six (6) months?_____

**3. Declaration by the Medical Attendant**

**I**_____ medical attendant of the below named person _____ _____ 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.

_____
**Signature of Doctor with Stamp**
Date _____
Place _____

_____
**Signature of Witness**
Name : _____
Address _____

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**PART 3 – EMPLOYER'S DETAILS**

**1. Details of the Employer**

e) Name of Employer _____

b) Address of Employer _____/_____

c) Telephone No. _____ d) email _____

e) Date of Appointment/ Account Open of Covered Person_____

**2. 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.

_____
**Authorized Signature with Stamp**
Date _____
Place _____

_____
**Signature of Witness**
Name : _____
Address _____

# Complaints in respect of insurance policy

"If you have any complaint or grievance against the insurance company, broker, agent, surveyor or bank representative in respect of your insurance policy, you may file your complaint with the following offices:

(1) **FEDERAL INSRANCE OMBUDSMAN**
2nd Floor, Pakistan Red Crescent Society
Annexe Building, Plot # 197/5
Dr. Doud Pota Road
Karachi.
Phone: 021-99207761-62
Website: www.fio.gov.pk/

(2) **Official Coordinator, Small Disputes Resolution Committee(Islamabad)**
The Management Executive, Insurance Division, 3rd Floor, NIC Building, 63-Jinnah Avenue,Blue Area, Islamabad.
Phone: 051-9207091-4 ext. 439
Email: complaints@secp.gov.pk

(3) **Official Coordinator, Small Disputes Resolution Committee (Karachi)**
The Deputy Director, Specialized Companies Division, 5th Floor, State LifeBuildingNo.2,Wallace Road Off. I.I. Chundrigar Road, Karachi.
Phone: 021-32414204
Email: complaints@secp.gov.pk

(4) **Official Coordinator, Small Disputes Resolution Committee(Lahore)**
The Deputy Registrar of Companies, Company Registration Office-Lahore, AssociateHouse, 3rd& 4th Floor, 7-Egerton Road, Lahore.
Phone: 042-99204962-66 ext. 28
Email: complaints@secp.gov.pk

# بیمہ پالیسی کے متعلق شکایات

اگر آپ کو اپنی بیمہ پالیسی کے متعلق انشورنس کمپنی، بروکر، ایجنٹ، سروئیر یا بینک نمائندے کے خلاف کوئی شکایت ہو تو آپ درج ذیل دفاتر میں رابطہ کر سکتے ہیں:۔

وفاقی انشورنس محتسب۔
سیکنڈ فلور، پاکستان ریڈ کریسنٹ سوسائٹی، انیکسی بلڈنگ،
پلاٹ نمبر 197/5، ڈاکٹر داؤد پوتا روڈ، کراچی
فون: 021-99207761-62
www.flo.gov.pk

دفتری رابطہ کار (اسلام آباد)
اسمال ڈسپیوٹس ریزولوشن کمپنی
سیکورٹیز اینڈ ایکسچینج کمیشن آف پاکستان
تھرڈ فلور، این آئی سی ایل بلڈنگ، اسلام آباد
فون: 051-9207091-4 ایکسٹینشن 439
ای میل: complaints@secp.gov.pk

دفتری رابطہ کار (لاہور)
اسمال ڈسپیوٹس ریزولوشن کمپنی
سیکورٹیز اینڈ ایکسچینج کمیشن آف پاکستان
ایسوسی ایٹ ہاؤس، 3rd فلور، 07- ایجرٹن روڈ، لاہور۔
فون نمبر: 042-99204962-66 (Ext 28)
ای میل: complaints@secp.gov.pk

دفتری رابطہ کار (کراچی)
اسمال ڈسپیوٹس ریزولوشن کمپنی
سیکیورٹیز اینڈ ایکسچینج کمشن آف پاکستان
5th فلور، اسٹیٹ لائف بلڈنگ 02، ولاس روڈ،
آف آئی آئی چندریگڑھ، کراچی۔
فون: 021-32414204