DISABILITY CLAIM FORM - GROUP LIFE & INDIVIDUAL LIFE

CLAIM FORM : ☐ GROUP LIFE ☐ INDIVIDUAL LIFE

Form Completion Instruction :

1) This form may be completed by those having a claim for disability benefits as a person nominated by the Policy Holder, Guardian, Assignee, Trustee or a successor
2) Please fill the form with single pen without omissions / deletions
3) Please complete the form with legible handwriting, incomplete form may cause delay in processing of disability claim benefits

CHECKLIST OF DOCUMENTS REQUIRED (Any other requirement(s) may be requested on claim where deem necessary):

1. Treatment Records (Original) ☐
2. Hospital Discharge Certificate ☐
3. Copy of CNIC - Claimant ☐
4. Copy of Passport (If Living Abroad) ☐
5. Attendance Record ☐
6. Salary Record - Last Drawn ☐

*In order to validate the claim, TPL Life Insurance Limited reserve the right to ask for further requirements, if deemed nece ssary.

CLAIM FORM A: INFORMATION ABOUT CLAMAINT / Policy holder

(To be completed by the claimant)

Name of Company / Claimant: _____

CNIC : _____ Marital Status : _____

Gender : _____ Contact No. : _____

D.O.B : _____ Policy No. : _____

Claiming as: ☐ Self ☐ Nominee ☐ Beneficiary ☐ Guardian

EVENT DETAILS

Type of Disability: ☐ Natural ☐ Accidental Place of Event, if Accidental: _____

Accidental / Illness Details: _____

Date of occurrence of disability / illness: _____ Last Day of Work: _____

Date of Joining Usual Work: _____ Nature of Work: _____

Have any life coverage with some other insurance company? (If Yes, provide detail)

Sr. No.	Name of Company	Policy No.	Issuance Date	Address and Contact No.
1				
2				
3				

Provide following details while consultation with any physician details of present illness and disability:

Sr. No.	Name of Hospital / Doctor	Complaint About	Treatment Duration	Contact No.	Breif Description about Present Condition
1					
2					

DECLARATION : I/We, as a claimant, hereby declare that the information provided in the form are true and complete to the best of my/our knowledge, belief, and record. I also hereby authorize TPL Life Insurance Limited in order to seek information from any doctor, hospital, laboratory, any other organization or person that has any record information or acknowledge of health/treatment and from any other Insurance / Takaful company to which a proposal has any time been made, and the giving of such information.

_____ Claimant Signature
(For Group Life, need duly stamped)

_____ Date of Statement

CLAIM FORM B: PHYSICIAN STATEMENT

(To be completed by the Attending Physician)

CLAIMANTS INFORMATION:

Claimant Name: _____

CNIC#: _____ Contact No. : _____

Gender : _____ Marital Status: _____

D.O.B : _____ Occupation: _____

EVENT INFORMATION

Events Dates:

Date of Event (Injury / Illness) : _____

Date on which claimant was unable to work: _____

Date on which claimant will be fit to perform office work: _____

Claimant first visit for present illness /injury : _____

Claimant last visit for present illness /injury : _____

Briefly describe the state of health of claimant since his/her first visit: _____

Give Symptoms, Diagnosis and Prognosis of Disability: _____

BMI: Height: _____ Weight: _____

Other Laboratory Findings (X-ray, ECG etc): _____

Please provide detail if any other physician attended claimant for any injury / illness:

Sr. No.	Name of Hospital / Doctor	Treatment Duration	Contact No. & Address	Cause
1				
2				

DECLARATION:

I_____medical attendant of the life insured_____do hereby declare that to the best of my knowledge and belief the information given herein are true and complete.

Signature & Duly Stamp with date:

TPL Life Insurance Limited

Window Takaful Operations

19-B, Lane 3, SMCHS, in the lane of Roomi Masjid,

Shahrah-e-Faisal, Karachi, Pakistan.

Email: claims@tpllife.com

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