Islaiming as: Self Nominee Beneficiary Guardian EVENT DETAILS ype of Disability: Natural Accidental Place of Event, if Accidental: ccidental / Illness Details:	+TPLLIfe		NSABILITY	CLAIMFOR	RM-GROU		NDIVIDUAL LIF
This form may be completed by those having a claim for disability benefits as a person nominated by the Policy Holder, fuardian, Assignee, Trustee or a successor Please filt the form with single pen without omissions / deletions Please filt the form with single pen without omissions / deletions Please filt the form with single pen without omissions / deletions Please filt the form with single pen without omissions / deletions Please filt the form with single pen without omissions / deletions TreatmentRecords (Original) 4. Copy of Passport (If Living Abroad) . TreatmentRecords (Original) 5. Attendance Record . Copy of CNIC-Claimant 6. Salary Record - Last Drawn order to validate the claim, TPL Life Insurance Limited reserve the right to ask for further requirements, if deemed nece ss CLAIM FORM A: INFORMATION ABOUT CLAMAINT / Policy hold (To be completed by the claimant) arme of Company / Claimant: NIC: Marital Status : . O.B : Policy No. : . O.B : Policy No. : . O.B : Policy No. : . Iaming as: Self Nominee . Beneficiary Guardian EVENT DETAILS Nature of Work: ate of occurrence of disability / illness: Last Day ofWork: ate of occurrence of	CLAIM FORM :		GROUP LIFE		INDIVIDUA	L LIFE	
Treatment Records (Original) A. Copy of Passport (If Living Abroad) Hospital Discharge Certificate Copy of CNIC - Claimant Copy of CNIC - Claimant CLAIM FORM A: INFORMATION ABOUT CLAMAINT / Policy hold (To be completed by the claimant) Treatment of Company / Claimant: NIC: Arrital Status: Contact No.: Policy No.: Accidental Place of Event, if Accidental: Condatt / Illness: Last Day of Work: Tave any life coverage with some other insurance company? (If Yes, provide detail) Sr. No. Name of Company Policy No. Sr. No. Name of Company Policy No. Staunce Date Address and Contact No. Sr. No. Name of Complaint Treatment Contact No. Breif Description about Present Condition ECLARATION.; IWe, as a claimant, hereby declare that the information provided in the form are true and complete to the fmylour knowledge, belief, and record. I also hereby authorize TPL Life Insurance Limited in order to seek information for) This form may be con Guardian, Assignee, Tr) Please fill the form v	npleted by those rustee or a succ vith single pen	cessor without omissi	ons / deletions		-	-
(To be completed by the claimant) arme of Company / Claimant: NIC: Marital Status : ender : Contact No. : O.B: Policy No. : laiming as: Self Nominee Beneficiary Guardian EVENT DETAILS ype of Disability: Natural Accidental Place of Event, if Accidental: ccidental / Illness Details: Last Day ofWork: tast of occurrence of disability / illness: ate of occurrence of disability / illness: ate of occurrence of disability / illness: Last Day ofWork: tave 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 Image: Company in the physician details of present illness and disability: Sr. No. Name of Complaint Treatment Contact No. Breif Description about Present Condition Image: Complaint 1 Image: Complaint	Treatment Records (Hospital Discharge C Copy of CNIC - Claima	Original) ertificate ant		4. Copy of Pass 5. Attendance R 6. Salary Record	oort (If Living Ab ecord - Last Drawn	proad)	
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Bender : Contact No. : D.B : Policy No. : Do.B : Policy No. : Policy No. : Beneficiary Guardian EVENT DETAILS ype of Disability: Natural Accidental Place of Event, if Accidental: ccidental / Illness Details: ate of occurrence of disability / illness: Last Day of Work: ate of Joining Usual Work: Nature of Work: ate of Joining Usual Work: Name of Company Policy No. Issuance Date Address and Contact No. 1 2 3 rovide following details while consultation with any physician details of present illness and disability: Sr. No. Name of Complaint Treatment Duration Contact No. Complaint Treatment Duration Contact No. ECLARATION : I/We, as a claimant, hereby declare that the information provided in the form are true and complete to the fmy/our knowledge, belief, and record. I also hereby authorize TPL Life Insurance Limited in order to seek information fm		Jaimant:		Marital Status:			
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2 <u>ECLARATION</u> : I/We, as a claimant, hereby declare that the information provided in the form are true and complete to the f my/our knowledge, belief, and record. I also hereby authorize TPL Life Insurance Limited in order to seek information from	Sr. No. Hospita	l / Doctor		Duration	Contact No.	Ċ	ondition
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ny doctor, hospital, laboratory, any other organization or person that has any record information or acknowledge of ealth/treatment and from any other Insurance / Takaful company to which a proposal has any time been made, and the gi	-		-		-		-

Claimant Signature (For Group Life, need duly stamped)

of such information.

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Date of Statement

	<u>CLAIN</u>		<u>3</u> : PHYSIC		EMENT	
	NFORMATION:	(To be com	pleted by the Attend	ing Physician)		
Claimant Na						
CNIC#:			Contact No.:			
Gender:		-	Marital Status:			
D.O.B:			Occupation:			
0.0.0.		-	occupation			
		EV	ENT INFORMAT	ON		
Events Dates	5:					
Date of Ever	nt (Injury / Illness) :			Claimant first visi	t for present	
Date on whi	ch claimant was unable to	work:		illness /injury :		
Date on wh	ich claimant will be fit to			Claimant last visi	tforpresent	
perform offi	ce work:			illness /injury :		
Briefly desc	ribe the state of health o	f claimant since	his/her first visit:			
Give Sympt	oms, Diagnosis and Pro	gnosis of Disabil	lity:			
BMI:		Woight:				
	Height:	Weight:		-		
Other Labor	ratory Findings (X-ray, E	CG elc):				
Please prov	ride detail if any other ph	vsician attended	l claimant for any	iniury / illness:		
	Name of	Treatment	1			
Sr. No.	Hospital / Doctor	Duration	Contact No.	& Address	Cause	
1						
2						
DECLARATIC	<u> </u>					
I			ant of the life ins			lo hereby
declare that	to the best of my knowle	dge and belief th	e information giv	en herein are tru	ie and complete.	
						1
Signature & Duly Stamp with date:						
						J

TPL Life Insurance Limited

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 Insurance Ombudsman

2nd Floor, Pakistan Red Crescent Society, Annexe Building, Plot# 197/5, Dr. Doud Pota Road, Karachi. Phone: 021-99207761-62 Website: <u>www.fio.gov.pk/</u>

2. Official Coordinator, Small Disputes Resolution Committee -Karachi

The Deputy Director, Specialized Companies Division 5th Floor, State Life Building No. 2, Wallace Road, Off. I.I. Chundrigar Road, Karachi. Direct no.: 021-99002021 UAN: 021-111-117-327 Email: <u>complaints@secp.gov.pk</u>

3. Official Coordinator, Small Disputes Resolution Committee -Lahore

The Deputy Registrar of Companies, Company Registration Office, Lahore. Associate House, 3rd & 4th Floor, 7-Egerton Road, Lahore. Direct no.: 042-99014050 UAN: 042-111-117-327 Email: <u>complaints@secp.gov.pk</u>

4. Official Coordinator, Small Disputes Resolution Committee-Islamabad

The Management Executive, Insurance Division 3rd Floor, NICL Building, Islamabad. Direct no.: 051-9195391 UAN: 051-111-117-327 Email: <u>complaints@secp.gov.pk</u>

5. Securities and Exchange Commission of Pakistan Toll-Free No.: Toll free 080088008



اگرآ پکواینی بیمہ پالیسی کے متعلق انشورنس کمپنی، بروکر، ایجنٹ، سروئیر پایپنک نمائندے کےخلاف کوئی شکایت ہوتو آپ درج ذیل دفاتر میں رابطہ کر سکتے ہیں :۔

وفاقى انشورنس متحسب سيكند فلور، ما كىتان رېد كرينىپ سوسائچ، انيكسى بلدنگ، يلا ينجبر 197/5، ڈاكٹر داؤد يوتارو ڈ، كراچى

فوٰن: 021-99207761-62 www.fio.gov.pk

دفتري رابطه كار (اسلام آياد) اسال ڈسپوٹس ریز ولوثن کمپنی سيكور طيز ايند الكسيينج كميش آف باكستان تحر د فلور، این آئی سی ایل بلڈیگ، آسلام آیاد

براهراست نمبر : 051-9195391 ایوانے این : 051-111-117-327 ای میل : complaints@secp.gov.pk

دفتري رابطه كار (لا مور) اسمال ڈسپیوٹس ریز ولوثن کمپنی سكور ثير ابتد المسيخ كميش آف ياكتان ايپوي ايٺ ماؤس، 3rd فلور، 07- ايچڻن روڈ،لا ہور براه راست نمبر: 042-99014050

یوات]ین: 042-111-117-327 ای میل: complaints@secp.gov.pk

سيكيور ٹيز اينڈ ا^{يم چ}ينج كميشن آف پاکستان ٹول فری نمبر: **080088008** ٹول فری

دفتري رابطه کار (کراچ) اسال دُسپوٹس ریز ولوثن کمپنی سکیو رٹیز اینڈ ایسپنج کمشن آف پاکستان 5th فلور، اسٹیٹ لائف بلڈنگ 02، ولاس روڈ، آف آئي آئي چندريگر روڈ، کراحي۔ براه راست نمبر : 021-99002021 پاسے این : 021-111-117-327 ای کیل: complaints@secp.gov.pk