Claim Form
DIB Complementary Takaful Coverage

Kindly fill the following form in case of any claim arising under the following:

1) Personal Accident Takaful (Accidental Death or Permanent Total Disability)
2) Golf Equipment Takaful
3) Household Takaful
4) ATM Cash Withdrawal/Over the Counter Cash Withdrawal Takaful
5) Health Takaful

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 to products.bank@salaamtakaful.com via email or Operations Dept. (Non-Motors), Salaam Takaful Limited, Business Centre, 6th Floor, Block 6, PECHS, Shahrah-e-Faisal, Karachi via mail.

CNIC No. of the Account Holder _____ Claim No._____

Account no. _____ Bank Segment: Mass ☐ Business ☐ Priority ☐

Policy no. _____

This form is issued without admission of liability and must be completed and returned within **seven days after its receipt**. No claim can be admitted unless a medical certificate overleaf be furnished at the expense of the Claimant.

GENERAL INFORMATION

Account Holder's Name in Full:	
Email:	
Contact No.:	
Residence:	
Business Address:	

TO BE FILLED FOR PERSONAL ACCIDENT TAKAFUL CLAIM

When Did The Accident Occur?	DATE:		TIME:	
Where Did the Accident Occur?				
What Is the Cause of The Accident?				
Name and Addresses of Witnesses (If Any)				
When Was the Police Notified of The Incident (If Applicable)				
Is/Was the Participant Covered Somewhere Else As Well?	Yes ☐ No ☐			
Name of The Last Medical Attendant				
Address of The Last Medical Attendant				
State the Number of Days the Participant Has Been Confined to Bed	_____ days starting from _____			
In Case of Accidental Injury or Permanent Total Disability, Give Full Details of The Injuries:				
Kindly Attach the Fir And/or Medical Reports (If Required)				

TO BE FILLED FOR GOLF EQUIPMENT TAKAFUL CLAIM

Place of the event occurred:	
Date of loss:	
Nature of loss:	
Circumstances of the loss:	
Amount of loss:	
When was the police notified of the incident (if applicable)	
Kindly attach the copy of FIR, if applicable:	

TO BE FILLED FOR HOUSEHOLD TAKAFUL CLAIM

Address of the covered property:	
Date of loss:	
Nature of loss:	
Details of damages:	
Circumstances of the loss:	
Amount of loss:	
Are the damages repairable:	
When was the police notified of the incident (if applicable)	
When was the fire brigade notified of the incident (if applicable)	
Kindly attach the copy of FIR, if applicable:	

TO BE FILLED FOR ATM / OVER THE COUNTER (OTC) CASH WITHDRAWAL TAKAFUL CLAIM

Address of the ATM/OTC:	
Date of loss:	
Nature of loss:	
Circumstances of the loss:	
Amount of loss:	
When was the police notified of the incident (if applicable)	
Kindly attach the copy of FIR, if applicable:	

TO BE FILLED FOR HEALTH TAKAFUL CLAIM*

**By The Account Holder / Patient*

Please attach the following documents with the form:

1) Original itemized bill and original payment receipts, these should be issued on the official bill/receipt book of the hospital/Pharmacy/laboratory.

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			

2) Laboratory, Radiology, Ultrasound reports along with Doctor Prescriptions for the same.
3) Itemized, dated, bills of the medicines purchased, supported by Consultant prescriptions specifying quantity and respective dosage.
4) Hospital Discharge summary / card (in case of hospitalization)
5) Copy of Birth certificate (in case of delivery / childbirth)
6) Copy of death certificate, if any.
7) Copy of CNIC (and Health Card, if applicable)
8) Form attached in annexure – to be filled by attending doctor / hospital

Date of Birth	
Diagnosis / Treatment	
Date of Admission	
Date of Discharge	
Duration of Illness / Injury	
Total Amount Claimed	
Health ID # (if applicable)	

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 ACCOUNT HOLDER:

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 declare that I have received the injuries/loss above described and warrant the truth of the foregoing particulars in every respect, and I agree that I have made, or if I shall make, any false or untrue statement, suppression or concealment, my right to compensation shall be partially or absolutely forfeited at the discretion of the Company.

In case of health takaful claims only, 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 Salaam Takaful 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 Account Holder _____ Date _____

ANNEXURE

TO BE FILLED BY ATTENDING DOCTOR / 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, _____)

(Continued on next page)

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	