CLAIMANT'S STATEMENT-DEATH CLAIM (FORM "A")

Separate form to be completed by each Claimant entitled to make Claim under the Membership

Jubilee FAMILY TAKAFUL

GUIDELINES FOR COMPLETION OF THE FORM

1. Please complete the form in all respects. Do not leave any column blank or incomplete. Please provide details. Use seperate sheets if required.
2. Where boxes have been provided to facilitate your reply, please only tick the relevant box. Leave the remaining boxes unmarked.
3. Please write in neat legible script. Do not use abbreviations, dots, crosses and dashes. Do not overwrite, mutilate, cancel, or delete. In case inadvertently, an error has occurred, then please correct neatly under your full signature.
4. Please sign this form in the same signature & style that you affixed on your CNIC. In case your signature now differs then please provide a set each of three specimen signature in both styles duly attested by the witness / attestor of this form.
5. This form along with any other form / document required to be completed & submitted to the Company should be delivered directly to the Head Office of the Company at the address mentioned at the bottom of this form. The Company shall not be responsible for any form that is not received by it at the Head Office of the Company.

Membership: _____ Member: _____

Person Covered: _____

A: IDENTIFICATION OF THE CLAIMANT:

1. Name Mr./Ms./Mrs. _____ 2. Age _____

3. Father's / Husband's Name _____ 4. C.N.I.C.No _____

5. Relationship with the Deceased _____

6. Status as Claimant _____

(Please state exact and complete relationship)

7. If Claim is being lodged by Guardian on behalf of a Minor (person below 18 years of age), Please specify

I. Minors Name _____ ii. Age _____

iii. Sex _____ iv. Minor's relationship with _____ (a). Deceased _____ (b). Claimant _____

8. Claimant's Complete Residential Address _____

Telephone No _____

9. Claimant's Complete Official Address _____

Telephone No _____

10. Claimant's Bank Account No, Title & Branch _____

11. Email ID & Forigen Contact Number of Claimant. _____

B: INFORMATION ABOUT THE DECEASED:

1. Name Mr./Ms./Mrs. _____ 2. Age at Death _____

3. Father's / Husband's Name _____ 4. C.N.I.C.No _____

5. Resident Of _____

(Complete address including specific Locality in City / Town / Village)

6. What was the deceased's Occupation/ Profession / Designation? _____

7. Where did the deceased work? _____

(Name & Address of the place of work)

8. What was the nature of his duties and what work did he perform? _____

9. State Deceased's _____ (a) Height _____ (b) Weight _____ (c) Identification Marks _____

10. State Deceased's Habits / Hobbies / Past-times _____

(Habits would include smoking, alcohol intake, drug use)

11. Did the deceased have any other Insurance Policy/Takaful Membership on his / her life? If so please provide details. _____

12. Please state the Name, Relationship, Age of all the Legal heirs of the deceased. (use a separate sheet if necessary)

13. Was the deceased ever affiliated / involved with any political / religio-political organization or group?

If **Yes** please provide details. _____

14. Place of Death _____

B: INFORMATION ABOUT THE DECEASED:

1. Sum Covered under (Membership type) _____ Amount Rs. _____

2. Supplementary Contract (Type) _____ Amount Rs. _____

3. Supplementary Contract (Type) _____ Amount Rs. _____

Total Rs. _____

D: CIRCUMSTANCES OF DEATH:

1. Reason Of Death ☐ Sickness ☐ Accident ☐ Homicide ☐ Suicide ☐ Self-inflicted Injury ☐ Other

2. Cause of Death: _____
(Description of the Illness / Disability / Injury / Medical Condition that was the immediate cause of death)

3. Date of Death _____ 4. Place of Death _____
Date Month Year

5. Complete Narration of the incident leading to / causing death: _____

6. In your opinion what other secondary medical condition(s), habits, lifestyle, work-related factors, social / political affiliation of the person covered caused or contributed or aggravated circumstances leading to death. Please provide details with dates.

_____

_____
(list all factors-medical, physical, mental, hereditary, environmental, habits, stress - that in your opinion caused or contributed to the onset of the disease)

7. Did the deceased have any past / recent history of physical or mental, illness/disability/deformity/injury ☐ Yes ☐ No

If **Yes** please provide details of the ailment / medical condition with date of occurance.

_____

_____

8. Prior to death was the deceased treated / attended by any Doctor / Hospital / Nursing Home / Clinic? ☐ Yes ☐ No

If **Yes** please provide details of treatment / admission with location & dates.

_____

_____

9. In the past 5 (five) years was the deceased ever attended by any Doctor or admitted to any Hospital / Clinic for any physical or mental, illness / disability / deformity / injury / medical condition? ☐ Yes ☐ No

If **Yes** please provide name & Address of doctor / medical facility with dates & details of the medical problem / condition.

Name & Address _____ Date _____ Treated for : _____

Name & Address _____ Date _____ Treated for : _____

Name & Address _____ Date _____ Treated for : _____
(Details are required - Use a separate sheet if necessary)

10. Did any blood relative of the deceased have an ailment or medical condition similar to or related to the disease or medicalcondition from which the deceased died? Please provide details with dates.

_____

_____

11. Do you know of any medical tests and examinations that the deceased underwent? ☐ Yes ☐ No

If **Yes** what medical condition were these tests & examinations for? What were their results & findings? When & where were these tests/examinations conducted?

_____

_____
(Name & Address of the Medical Facility(ies)with specific dates are required - Use a separate sheet if necessary)

12. In case of death due to Accident / Homicide / Suicide / Self-inflicted injury, was an FIR lodged? Was an Autopsy / Post-Mortem performed? Has a Medico-legal Report been obtained? Please specify and provide copies.

_____

DECLARATION & AUTHORIZATION

The undersigned, hereby makes claim to said takaful, and agrees that the written statements and affidavits of all the physicians who attended to or treated the covered shall constitute part of these Proofs of Death, I further state that the above statements are true and complete to the best of my knowledge and belief. I, hereby, authorize any physician, clinic, hospital, medical body, takaful company, my employer, any organization, friend, relative person that has any information, record or knowledge of health or medical history of the above named deceased to provide the same to Jubilee Life Insurance Company Limited-Window Takaful Operations. A photocopy of this authorization shall be as valid as an original.

Dated at _____ this _____ day of _____ 20 _____
(Place) *(Date)* *(Month)* *(Year)*

Signature of Claimant _____ Signature of Attestor/Witness _____

Full Name of Claimant _____ Name of Attestor / Witness _____

C.N.I.C No. _____ C.N.I.C No. _____

Current Address of Claimants _____

Claimants Bank Account No and Branch _____

Form is to be witnessed and attested by an official of Jubilee Life Insurance Company Limited-Window Takaful Operations of designation not below Assistant Branch Manager / Assistant Manager or by an official of the Government of, Pakistan / Province of Pakistan under his / her official stamp & seal. The witness/attestor must submit a clear legible copy of his / her CNIC along with this form.

Jubilee Life Insurance Company Limited
Window Takaful Operations
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