ALKHALEEJ TAKAFUL GROUP مجموعة الخليج التكافلي

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GROUP LIFE & PERSONAL ACCIDENT ACCIDENT / SICKNESS

Claim No.....
Policy No.....

1. **INSURED'S NAME:** _____

2. **THE INJURED**

a) Name : _____ b) Emp. No.:_____

c) Nationality:_____ d) Age: _____ e) Occupation: _____

f) Salary: _____per month.

3. **THE ACCIDENT / SICKNESS**:

a) Place: _____. b) Date: ____/ _____/ _____ .c) Time: _____am/pm.

d) Circumstances and description of the accident / sickness: _____

_____

_____

e) Nature and Extent of Injury / sickness: _____

_____

4. **PROBABLE DURATION OF DISABLITY**

Was the injured totally disabled from attending his normal duty because of the above accident? If so, how many days and from which date onwards? _____

_____

P.T.O

5) **PTD / PPD DUE TO SICKNESS**:

In respect of PERMANENT TOTAL DISABILITY or PERMANENT PARTIAL DISABILITY due to Sickness:

1) Date of Contracting the Disease /Illness / Sickness.

_____

2) Nature of Disease /Illness / Sickness.

_____

3) Hospital's /Clinic's Report of treatment undergone.

_____

4) Certificate from the Hospital / Clinic certifying the permanency and extent of Disability.

_____

_____
Signature of the Member.

Date: _____/ _____/_____

_____
Signature of the Insured