تكافل شركة أبوظبي الوطنية للتكافل ش.م.ع
Takaful Abu Dhabi National Takaful Co. P.S.C

Group Disability Claim Form

1. Information to be provided by the employee

Name: ……

Address: ……

Date of birth: ……..Married (Yes/No)……..

Please state job title: …… Please give an exact description of duties:
……

Please describe the nature of disability: …….
……..

Which duties cannot be performed due to disability? …….
……

Which treatments are currently being undertaken? …….
……..

On what date did the symptoms of the disability first appear? …….

Please give details of medical attendants/hospitals/clinics where treatment has been received:…….
……
……

When do you expect to be able to return to work? …….

Are you currently receiving any State benefits? Are you currently receiving any benefits from other sources? (E.g. Individual Insurance, Workmen's Compensation benefits etc.:
……
……
……

Signature:…… Approval:…… Date:……

2. Information to be provided by the employer

Name of employee: ……

Job title of employee: …… Date employee joined the scheme: …….

Please give precise details of the employee's duties: ……..
……... ……

How long has the employee been employed in the present position? ……

Please describe the nature of the employee's disability? ……
……

On what date was the employee first absent from work? ……..

Have there been any previous absences due to the same or similar conditions? ……
……
……..
……..

Please give details of the employee's salary (including bonuses etc.) ……
……

Signature:…….. Approval:……. Date:…….

3. Information to be provided by Medical Attendant

Are you the normal medical attendant of the claimant? ……

For how long have you been the claimant's medical attendant? ……..

On what date were you first consulted for the claimant's disability? ……

Have there been any previous episodes of the current or similar conditions? ……..
…….

Please give a description of the symptoms: …….
…….

Please state the exact diagnosis of the current condition: ……....
…….

Does the claimant suffer from any other conditions simultaneously? ……...
……...

Since the first diagnosis, has the claimant's condition improved, or remained stable or worsened? …….
……... ……

Which aspects of the illness prevent the claimant from working? ……..
…….

Is the claimant unable to perform his / her normal occupation on a part–time basis? ..
……..

Will the patient in the future be able to resume his / her normal occupation? ……
……...

Please give details of treatments: ……..……
…… .

Please give details of consultations with specialists: …….
……

Please give details of any hospitalisations: ……
……

Signature:……Approval:……Date:……