Punjab Life
Insurance Company Limited

PUNJAB LIFE INSURANCE COMPANY LIMITED (PLIC)
DISABILITY CLAIM FORM

INSTRUCTIONS FOR COMPLETING THE CLAIM FORM:

1. This form may be filled by the **Employer (Claimant)**, or by an **Attorney, or Legal Representative** acting on their behalf where the Insured Person is incapacitated.
2. Attending physician statement must be filled by Doctor. (Physician form will not be accepted without a doctor's stamp)
3. Please complete the form using **one ink pen** only. Avoid any overwriting, erasures, omissions, or deletions.
4. Complete all sections of the form in **clear and legible handwriting**. Incomplete or illegible forms may result in delays in the processing of claim benefits.

CHECKLIST OF DOCUMENTS:

Checklist of Documents Required	Additional Requirements for Group Life	Additional Requirements (If Accidental Disability)
1. Employer's Statement	1. Salary Record (3 months)	1. Copy of FIR (if applicable)
2. Physician's Statement	2. Attendance Record (3 months)	2. Medico-Legal Report
3. CNIC of Employee	—	3. Newspaper Article Covering the Incident (if any)
4. Disability Certificate (Medical Board-if any)	—	4. Investigation Report (if any)
5. Medical Investigation Reports	—	—
6. Treatment Records	—	—

***Punjab Life Insurance Company Limited** reserves the right to request any additional documents or information that may be deemed necessary to assess, validate, and process the claim.

CLAIM FORM A: INFORMATION ABOUT EMPLOYER / CLAIMANT: |To be filled by the Employer|

Claimant Details	Information
Name of Company / Claimant	
Contact Person Name	
Contact Person Designation	
Claiming As	☐ Employer ☐ Self ☐ Nominee ☐ Legal Representative
Mobile No.	
Email ID	

Head Office: 1st Floor, Pakistan Engineering Congress Building, 97-A/D-1, Liberty Market, Gulberg III, Lahore.
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Claim Payment Information	
Payment Details	**Information**
Mode of Payment	☐ Cheque ☐ IBFT
Title of Account	
Account Number (IBAN)	
Bank Name	
Branch Name	
Amount of Claim	

CLAIM FORM B: EMPLOYER'S STATEMENT: |To be completed by the Employer / Policyholder|

Policy Information:			
Group Policy No.		Policy Commencement Date	____ / ____ / _____
Employee Information:			
Name of Employee		Designation	
Employee / Sr. No.		CNIC No.	
Date of Appointment	____ / ____ / _____	Effective Date of Coverage	____ / ____ / _____
Employment & Disability Status:			
Type of Disability Claim	☐ Accidental ☐ Natural (Sickness)	Date of Accident / Symptoms First Noticed	____ / ____ / _____
Date Employee Became Unable to Work (Starting Date)	____ / ____ / _____	Date Employer Discontinued Salary/Wage	____ / ____ / _____
Employee's Last Date at Work	____ / ____ / _____	Employee Returned to Work On	____ / ____ / _____
Current Employment Status	☐ On Duty ☐ Terminated ☐ On Sick Leave ☐ Temp. Laid Off	Expected Date of Rejoining	____ / ____ / _____
Reason for Stopping Work			
Salary & Coverage:			
Gross Salary / Wages (PKR) / Month		Total Sum Covered (PKR)	
Amount of Claim (PKR)			

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I certify that the above information is true and correct to the best of my knowledge.

Employer Signature & Seal:	**Date of Statement:** ____ / ____ / _____
Employer's Name (POC):	
Designation:	

CLAIM FORM B: PHYSICIAN'S STATEMENT: |To be completed by the Attending Physician or Medical Board|

Insured / Patient Name	
Father's / Husband's Name	
CNIC No.	
Date of Birth (DD/MM/YYYY)	
Address of Insured	
EVENT INFORMATION:	
Particulars	**Details**
Date of Disability	
Time of Disability (if applicable)	_____ AM / PM
Place of Incident	
Type of Disability	☐ Natural / Illness ☐ Accident
Name of Hospital (First Admission)	
Interval Between Onset of Illness/Injury and Disability	_____ Days
NATURE & EXTENT OF DISABILITY:	
Primary Diagnosis / Cause:	
Secondary Cause (if any):	
Clinical Findings:	
Whether Permanent or Temporary:	
Any other disease/illness the Insured is suffering from that did **not** cause the disability	

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EMPLOYMENT RELATION & HOSPITALIZATION:	
Date patient ceased work because of disability / event	____ / ____ / _____
Is the condition a result of an injury or illness caused by the patient's employment?	☐ Yes ☐ No
Has the patient been hospitalized? ☐ Yes ☐ No	
If yes, provide reason, hospital name, and dates of confinement:	
Has the patient been released from your care? ☐ Yes ☐ No	
If "Yes", date released from care: ____ / ____ / _____ If "No", date of next scheduled treatment or evaluation: ____ / ____ / _____	

PROGNOSIS:	
Is the disability presumed to be reversible?	☐ Yes ☐ No
Is patient now capable of performing duties? (If No, mention duration in days)	☐ Yes ☐ No
Do you anticipate a significant or fundamental change in the future? (If Yes, describe) ☐ Yes ☐ No	
Specify the date by which you presume the patient will be able to resume his duties/work: ____ / ____ / _____	

PAST MEDICAL HISTORY:	
Particulars	**Details**
First Consultation for Current Illness/Injury	____ / ____ / _____
Last Consultation for Current Illness/Injury	____ / ____ / _____
Prior to the current illness/injury, was the Insured under your regular medical consultation?	☐ Yes ☐ No
If yes, please provide details:	
Have you referred the Insured to any other physician or hospital for treatment?	☐ Yes ☐ No
If yes, please provide the following details:	
Medical Board Assessment Conducted?	☐ Yes ☐ No
If "Yes", please attach the Investigation Findings and/or Medical Board Report.	

DECLARATION:		
I hereby certify that the information provided in this Physician's statement is complete and best of my knowledge and belief.		
Attending Physician Name:		
Physician's / Medical Board Signature	**Official Stamp**	**Date**
		____ / ____ / _____

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