TAKAFUL MEDICAL CLAIM FORM

IGI Life Window Takaful Operations

A. CLAIMS SUBMISSION PROCEDURE

To avoid any delays in processing of your claim, please ensure that:

1. All questions on the form are to be answered. Do not leave any blank spaces. Use block letters.
2. All original claims documents are to be attached.
3. Attached copy of medical card.
4. **COMPLETE THE CHECK LIST.**

B. EMPLOYEE'S SECTION

1. Employee's Name & Date of Birth: _____
   (As shown on Enrollment Card Policy Listing)
2. Patient's Name & Date of Birth: _____
   (As shown on Enrollment Card Policy Listing)
3. Company Name: _____
4. Group Membership No: _____ Class/Plan: _____ Cert. / Member No.: _____
5. CNIC: _____ Employee No._____
6. Mobile No.: _____ Email Address: _____
7. Bank Name: _____ Account No: _____
8. Mailing Address: _____

_____

I hereby certify that all answers and all documents submitted with the Claim Form are complete and true. I hereby authorize any doctor, hospital, clinic or medical provider, any insurance company or any other company institution or any other person who has any record or information about me and I or any Takaful or Insurance of my family members to provide **IGI Life Window Takaful Operations** with the complete information, including copies of their records with reference to any sickness or accident, any treatment, examination, advice or hospitalization. Any photocopy of this authorization shall be taken as the original copy.
I also authorize **IGI Life Window Takaful Operations** to share my or my family's information with third parties if needed for processing of this claim.

Employee's Signature: _____ Date: _____

C. EMPLOYER'S SECTION

1. Is this claim arising out of Patient's Occupation? Yes ☐ No ☐
2. Payment cheque made in the name of Employee ☐ Employer ☐ Assigned Provider ☐
3. Total Amount Claimed: _____
4. Employer's Representative Signature: _____
5. Employer's Stamp: _____ Date: _____

D. FOR OFFICIAL USE ONLY

DOS 1	DOS 2	PC	DEP	CRVS	PROV	PAYEE	PRD	AC CD

BEN. CD	CLAIMED EXP.	APPROVED EXP.	

IGI Life Window Takaful Operations: 7th Floor, The Forum, Suite No. 701-713, G-20, Block 9, Khayaban-e-Jami, Clifton, Karachi-75600, Pakistan.
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E. ATTENDING PHYSICIAN'S SECTION

1. Patient's Name & Date of Birth: _____
2. Presenting Complaints: _____
3. Duration of Complaints: _____
4. Diagnosis (Block Letters): _____
5. Date symptoms first appeared: _____
6. If the claim is resulting from pregnancy/ children,

   Please provide date of (LMP or E.D.D): _____
7. Details of Treatment (other than prescription): _____
8. Dates of any previous treatment
   ingrowth name of treating physician: _____
9. If further treatment or operative procedure anticipated? YES ☐ NO ☐
   If "yes" Please provide full details & expected dates.

   _____

   _____
10. Name of Operation: _____
11. Date performed: _____

    Physician's/ Surgeon's Signature & Stamp: _____

    Date: _____

CLAIMS CHECK LIST

KINDLY ATTACH THE FOLLOWING WITH YOUR CLAIM.
(NOTE: ORIGINAL DOCUMENTS REQUIRED) **(Please tick)**

	YES	NO (REASON)
1. Itemized Hospital Bill & Receipts.		
2. Detailed Hospital Discharge Report.		
3. Itemized Laboratory & Radiology Bills.		
4. All Laboratory & Radiology Reports.		
5. Itemized Pharmacy Bills Along with Prescriptions		
6. Ultrasound, C.T. Scan, MRI Reports, etc.		
7. Others (If Any).		

IGI Contact Detail:
Claims Department
IGI Life Window Takaful Operations
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