

Claim Form for Group Family Credit Shield Takaful



Please complete this form in BLOCK letters using blue or black ink. Any unclear instructions will not be performed. Countersign all changes or corrections you make. Acceptance of this form does not mean that claim is approved by the Company.

Cardholder Details:		
Name : _____	Date of Birth: _____	
Address : _____	Sex : Male/Female	
_____	Mobile No. : _____	
Credit Card No. _____ -- _____ -- _____ -- _____		
Date of Issue: _____	Valid Until: _____	
Claim Details:		
Type of Claim : Death <input type="checkbox"/>	Permanent Total Disablement <input type="checkbox"/>	Hospitalization Cash Benefit <input type="checkbox"/>
Involuntary Loss of Employment <input type="checkbox"/>		
Date of Event : _____	Description of the Event: _____ -	

Death/Disablement Claims/Hospitalisation Cash Benefit (to be filled by the Cardholder/Cardholder's authorised representative)		
1. Give the date when the Cardholder first saw a doctor for condition that caused death/disablement: _____		
2. Was death/disablement/hospitalisation due to illness? <input type="checkbox"/> Accident? <input type="checkbox"/>		
3. Name and Address of the Family Doctor:		

Authorisation: I hereby authorise any physician, hospital, insurer, Medical Information Bureau or other Organisation or person having any records, data or information as may be requested by Bank / Takful Company or their duly authorised representative. I understand that in executing this authorisation, I waive the right for such information to be privileged. A photocopy of this authorisation shall be considered as effective and valid as the original.		
Date _____	Signed _____	
Address _____		
Involuntary Loss of Employment (to be filled by the Cardholder)		
1. Name and Address of the Company where the you were an employee:		

Tel: _____	Fax: _____	Email: _____

2. Employee ID _____ Designation _____
 Department _____ Location/Branch _____

3. Date when you were given notice of Unemployment: _____

4. Date of your actual Unemployment : _____

5. Details of any Notice Pay received : Amount _____ Period from _____ to _____

6. Reason for Termination : _____

7. If you are re-employed, pls give a) Date of re-employment : _____
 Name and address: _____

Tel: _____ Fax: _____ Email: _____

DECLARATION
 I/We hereby confirm that to the best of my/our knowledge, all statements and information mentioned above are true and correct, and that I/We have not concealed or misstated any material fact to Noor Takaful Family PJSC. I/We hereby acknowledge that all documents and reports which have been submitted to you for my/our application being part of the claim details information. Should this form be completed by third person on my/our behalf, I/We agree that all statements made by them shall be deemed to have been made by me/us to be my/our statements and I/We take full responsibility of the same. I/We further agree to allow Noor Takaful Family PJSC to take any necessary information from any doctor, individual or any authority in considering my/our application. I/We agree to fully cooperate with Noor Takaful Family PJSC and any other party acting on behalf of Noor Takaful Family PJSC in connection with this claim. If the benefit is to be paid directly to the claimant, relative or his/her representative, please state:

Date : _____ Signed : _____

Please attach the following documents

<p>1. for Death Claims</p> <ul style="list-style-type: none"> • Death Certificate issued by a competent authority • Post Mortem Report (wherever legally required) • Police Report (if death was due to an accident) • Medical Report from a licenced and registered medical officer with Detailed Diagnosis and Cause of Death if required by the Company when the actual cause of death is not clearly mentioned in the Death Certificate. • Copy of passport with visa page (where applicable / National ID card for Nationals) • Any other documents as may be required <p>2. for Permanent Total Disablement Claims</p> <ul style="list-style-type: none"> • Disability Certificate from an authorised medical practitioner to assess disability • Police Report (if disability is due to an accident) • Medical Report* from a licenced and registered medical officer with Detailed Diagnosis, Cause of Disability and Details of Treatment given (if any) 	<ul style="list-style-type: none"> • Copy of passport with visa page (where applicable / National ID card for Nationals) • Any other documents as may be required <p>3. for Hospitalisation Cash Benefit</p> <ul style="list-style-type: none"> • Police Report • Medical Report* from a licenced and registered medical officer • Discharge Summary. • Any other documents as may be required <p>4. for Involuntary Loss of Employment Claims</p> <ul style="list-style-type: none"> • Notice of Termination from the Employer • Copy of Passport with Visa Page (where applicable / National ID card for Nationals) • The Company may also request for a copy of the Labour Contract from the Employer if it is required to verify the period of employment contract. <p>Any other documents as may be required</p>
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IMPORTANT NOTICE:

Please submit the completed Claim Form along with the required documents to any of the Mashreqbank branches or mail to:
 Mashreqbank,
 Cardmember Services
 P.O. Box 1250
 Dubai
 United Arab Emirates.
 Fax: 04-2722793