## <u>COMPENSATION CLAIM ON MEDICAL / DEATH GROUNDS</u> <u>MEDICAL WELFARE SCHEME (AIRMEN)</u>

(RAISE IN TWO COPIES AND COMPLETE IN BLOCK CAPITALS)

## PERSONAL PARTICULARS

	2. NAME AS PER IIILE	OF BANK ACCOUNT:	3. PAK/NO:	4. TRADE:					
5. DATE OF BIRTH:	6. MEMBERSHIP NO:	7. UNIT:	8. STATUS:-						
3. DATE OF BIRTH.			(I) REGUL	AR AIR MAN					
			(II) RE-ENR						
9. DATE OF MWS REGISTRATION:		10. DATE OF MWS	10. DATE OF MWS CONTRIBUTION:						
11. ACCOUNT NO IBA									
12. BANK NAME& CO	DE NO:		13. BRANCH NAME:						
14. CELL NO:			15. E-MAIL ADD:						
16. ON MEDICAL GROUNDS. I HEREBY CONFIRM THAT: (A) MY MEDICAL CATEGORY HAS BEEN PERMANENTLY DOWN-GRADED FOR THE FIRST TIME SINCE BECOMING A MEMBER OF MWS (A). (B) I CONFIRM THAT I HAVE NOT RECEIVED ANY COMPENSATION BEFORE AND I AM ENTITLED TO MEDICAL COMPENSATION UNDER TERMS AND CONDITIONS OF MWS (A). (C) AS PER MEDICAL BOARD REPORT, THE DISEASE, RESPONSIBLE FOR DOWN-GRADATION OF MY MEDICAL CATEGORY, ORIGINATED AFTER THE EFFECTIVE DATE, I STARTED CONTRIBUTING TO MWS (A).									
17. <u>ON DEATH GROUNDS.</u> I HEREBY CONFIRM THAT: - (A) THE ABOVE NAMED AIRMAN WAS A REGULAR MEMBER OF MWS (A). (B) HE / SHE DIED ON (C) I AM HIS / HER NOMINATED NEXT OF KIN (NOK) AND THEREFORE, CLAIMING DEATH COMPENSATION UNDER THE TERMS / CONDITIONS OF MWS (A).									
18. THE COMPENSAT	ION ON MEDICAL / DEATH	GROUNDS MAY PLEAS							
TRANSACTION / BANK	DRAFT / CHEQUE" IN MY F RELATIONSHIP: 0	AVOUR. CELL NO:	E-MAIL ADD	:					
				-					
CNIC NO.			s	IGNATURE					
19. IT IS CERTIFIED THAT MEDICAL COMPENSATION / DEATH CLAIM IN RESPECT OF ABOVE MENTIONED AIRMAN IS CORRECT AND ALL COLUMNS HAVE BEEN DULY FILLED UP.									
	DATE		SIGNAT	URF WITH STAMP					
				URE WITH STAMP					
VERIFICATION BY S	HAHEEN FOUNDATION		R & WEL)						
VERIFICATION BY S 20. THE ABOVE MEN	HAHEEN FOUNDATION		<b>R &amp; WEL)</b> 1 HAS BEEN VERIF						
VERIFICATION BY S 20. THE ABOVE MEN CORRECT / INCORREC DATE: APPROVAL BY MAN	HAHEEN FOUNDATION	ISATION / DEATH CLAIN	<b>R &amp; WEL)</b> 1 HAS BEEN VERIF	IED AND FOUND					
VERIFICATION BY S 20. THE ABOVE MEN CORRECT / INCORREC DATE:	HAHEEN FOUNDATION TIONED MEDICAL COMPEN CT.	ISATION / DEATH CLAIN	<b>R &amp; WEL)</b> 1 HAS BEEN VERIF	IED AND FOUND					
VERIFICATION BY S 20. THE ABOVE MEN CORRECT / INCORREC DATE: APPROVAL BY MAN 21. APPROVED / NOT	HAHEEN FOUNDATION TIONED MEDICAL COMPEN CT. AGING DIRECTOR SHAP	ISATION / DEATH CLAIN	TR & WEL) THAS BEEN VERIF SIGNAT	TURE WITH STAMP					
VERIFICATION BY S 20. THE ABOVE MEN CORRECT / INCORREC DATE: APPROVAL BY MAN 21. 21. 22. BANK DRAFT /	HAHEEN FOUNDATION TIONED MEDICAL COMPEN CT.	ISATION / DEATH CLAIN	TR & WEL) THAS BEEN VERIF SIGNAT	TIED AND FOUND					
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VERIFICATION BY S 20. THE ABOVE MEN CORRECT / INCORREC DATE: APPROVAL BY MAN 21. 22. BANK DRAFT / RS: IS I DATE : RECEIPT AND COUN 23. THE ABOVE ONLI TO THE CLAIMANT.	HAHEEN FOUNDATION ( TIONED MEDICAL COMPEN CT. AGING DIRECTOR SHAI APPROVED CHEQUE NO ENCLOSED FOR HANDING	ISATION / DEATH CLAIN	TR & WEL) THAS BEEN VERIF	TURE WITH STAMP					

SHAHEEN FOUNDATION

PAF

Note:- This form can be downloaded from PAF Intranet and can be sent by post to Head Office, Shaheen Foundation, duly filled in & signed by the applicant and countersigned by Unit Commander.

## <u>COMPENSATION CLAIM ON MEDICAL / DEATH GROUNDS</u> <u>MEDICAL WELFARE SCHEME (AIRMEN)</u>

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## PERSONAL PARTICULARS

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1. RANK :	2. N	IAME A	S PER T	ITLE OF	BANK	ACCO	UNT:	3. <b>P</b>	AK/NO:		4. TRADE:		
5. DATE OF BIRTH:	6. N	IEMBE	rship n	<b>0:</b> 7.	UNIT:			8.	8. STATUS:- (I) REGULAR AIRMAN				
9. DATE OF MWS R		10. <b>E</b>	DATE O	FMWS		RIBUTIO	N:						
11. ACCOUNT NO IB	AN:												
12. BANK NAME& C	13. BRANCH NAME:												
14. CELL NO:					15. E-MAIL ADD:								
16. ON MEDICA PERMANENTLY DOV CONFIRM THAT I H COMPENSATION UN DISEASE, RESPONS EFFECTIVE DATE, I S 17. ON DEATH GR MEMBER OF MWS (/	WN-GRA AVE NO DER TE SIBLE FO STARTEL OUNDS.	DED F DT REC RMS A DR DO D CONT	OR THE EIVED ND CON WN-GRA RIBUTIN REBY C	FIRST ANY CO IDITION ADATION IG TO M ONFIRM	TIME MPENS SOFM OFM WS(A) THAT:	SINCE SATION IWS (A) IY MEI - (A) T	BECO BEFOI (C) A DICAL ( THE AB(	MING RE AN S PER CATEC	A MEME ID I AM MEDICA GORY, O	BER ENT L BO RIGI	ITLED TO MÉ DARD REPOR NATED AFTEF	. (B) I DICAL T, THE R THE GULAR	
(NOK) AND THEREFO													
18. THE COMPENS TRANSACTION / BAN						DS MAY	PLE AS	SE BE F	REMITTEI	D TH	IROUGH "ONLI	NE	
NAME:			ONSHIP		L NO:				E-MAIL A	DD:			
CNIC NO.										SI	GNATURE		
REMARKS BY UNI			R										
UNIT: VERIFICATION BY					IDECT					NAT	URE WITH STA	AMP	
20. THE ABOVE ME CORRECT / INCORRI	NTIONE	D MED	IC AL CO	MPENS	ATION /	DEATH	H CLAIN	THAS	BEEN VE	RIFI	ED AND FOUN	D	
DATE:									SIG	NAT	UREWITHST	AMP	
APPROVAL BY MA	NAGIN		ECTOR	SHAHE	EN FO	UNDA	TION						
21.		OVED							SIG	ΝΔΤΙ	URE WITH STA	MP	
22. BANK DRAFT / CHEQUE NO						DATED, AMOUNTING TO							
RS:I	SENCLO	DSED F	OR HAN	DING O'	VER TO	) THE C	LAIMAN	NT.					
DATE :									SIGNATU	RE	DIRECTOR FIN	ANCE	
RECEIPT AND COU 23. THE ABOVE ON TO THE CLAIMANT.								BEEN I	RECEIVEI	d an	ID HANDED O\	/ER	
SIGNATURE OF CLA	IMANT		DA	TE:			COUNT	ER SI	GNATURI	EOF		NDER	
Note: - This form c	an be d	ownloa	aded fro	m PAF	Intrane	et and	can be	sent	by post	to H	ead Office, Sl	haheen	

Foundation, duly filled in & signed by the applicant and countersigned by Unit Commander.

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