



**COMPENSATION CLAIM ON MEDICAL / DEATH GROUNDS**  
**MEDICAL WELFARE SCHEME (AIRMEN)**

(RAISE IN TWO COPIES AND COMPLETE IN BLOCK CAPITALS)

**PERSONAL PARTICULARS**

|   |                               |            |   |
|---|-------------------------------|------------|---|
| 1. RANK :   | 2. NAME:                      | 3. PAK/NO: | 4. TRADE:   |
| 5. DATE OF BIRTH:   | 6. MEMBERSHIP NO:             | 7. UNIT:   | 8. STATUS: -<br>(I) REGULAR AIRMAN <input type="checkbox"/><br>(II) RE-ENROLLED AIRMAN <input type="checkbox"/> |
| 9. DATE OF MWS REGISTRATION:  | 10. DATE OF MWS CONTRIBUTION: |            |   |
| 11. CELL NO:  | 12. E-MAIL ADD:               |            |   |
| 13. <b>ON MEDICAL GROUNDS.</b> 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) I WAS LESS THAN 45 YEARS OF AGE ON THE DATE OF DOWN-GRADATION OF MEDICAL CATEGORY. (D) 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). |                               |            |   |
| 14. <b>ON DEATH GROUNDS.</b> 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).  |                               |            |   |
| 15. THE COMPENSATION ON MEDICAL / DEATH GROUNDS MAY PLEASE BE REMITTED THROUGH "BANK DRAFT / CHEQUE" IN MY FAVOUR.  |                               |            |   |
| NAME:   | RELATIONSHIP:                 | CELL NO:   | E-MAIL ADD:   |
| CNIC No.  | <input type="text"/>          |            | SIGNATURE   |

**REMARKS BY UNIT COMMANDER**

|   |       |                      |
|---|-------|----------------------|
| 16. IT IS CERTIFIED THAT MEDICAL COMPENSATION / DEATH CLAIM IN RESPECT OF ABOVE MENTIONED AIRMAN IS CORRECT AND ALL COLUMNS HAVE BEEN DULY FILLED UP. |       |                      |
| UNIT:   | DATE: | SIGNATURE WITH STAMP |

**VERIFICATION BY SHAHEEN FOUNDATION (DIRECTOR ADMIN H/R & WEL)**

|   |                      |
|---|----------------------|
| 17. THE ABOVE MENTIONED MEDICAL COMPENSATION / DEATH CLAIM HAS BEEN VERIFIED AND FOUND CORRECT / INCORRECT. |                      |
| DATE:   | SIGNATURE WITH STAMP |

**APPROVAL BY MANAGING DIRECTOR SHAHEEN FOUNDATION**

|                         |                      |
|-------------------------|----------------------|
| 18.                     |                      |
| APPROVED / NOT APPROVED | SIGNATURE WITH STAMP |

|   |                            |
|---|----------------------------|
| 19. BANK DRAFT / CHEQUE NO. _____ DATED _____, AMOUNTING TO RS: _____ IS ENCLOSED FOR HANDING OVER TO THE CLAIMANT. |                            |
| DATE :  | SIGNATURE DIRECTOR FINANCE |

**RECEIPT AND COUNTER SIGNATURE BY UNIT COMMANDER**

|  |       |                                     |
|--|-------|-------------------------------------|
| 20. THE ABOVE BANK DRAFT / CHEQUE HAS BEEN RECEIVED AND HANDED OVER TO THE CLAIMANT. |       |                                     |
| SIGNATURE OF CLAIMANT  | DATE: | COUNTER SIGNATURE OF UNIT COMMANDER |

**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.

SHAHEEN FOUNDATION COPY



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**PERSONAL PARTICULARS**

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| 11. CELL NO:   |  |                   |  | 12. E-MAIL ADD:               |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |           |  |
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| CNIC No. <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> |  |                   |  |                               |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | SIGNATURE |  |
|  |  |                   |  |                               |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |           |  |

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**INDIVIDUAL'S COPY**