AEGONLife

CERTIFICATE OF EMPLOYER - ACCIDENTAL DISABILITY/DISMEMBERMENT CLAIM

With respect to claim under Policy No _____ on the life of _____

_____ I hereby make the following statement:

Section I

a) Name of the Life Assured :

b) Date of Birth (as per records) : D D M M Y Y Y Y

c) Address of Life Assured :

d) Nature of Duties :

e) Date of joining : D D M M Y Y Y Y

f) Last date of service : D D M M Y Y Y Y

Section II

Was the Life Assured covered under any other medical insurance or reimbursement scheme - Yes / No.
If yes, Please provide us details of any disbursements made to the Life Assured for the past 3 years

Dates of illness	Particulars of illness	Amount Disbursed

Section III

Nature and Duration of leave (Please state nature of leave availed of i.e. Casual, Earned/ Privilege leave, Sick etc. during th e past three years. If sick leaves are taken and medical certificates are produced send copies of leave applications and certificates

Nature of Leave	Effective Date-Commencement	Effective Date resuming duties	Exact reason for availing leave

Section IV

a) Is the insured currently on leave? : ☐ Yes ☐ No

b) Is the insured still employed with you? : ☐ Yes ☐ No

c) If yes, what is his/ her current designation and nature of duties? :

Name of Witness : _____

Address : _____

_____

Tel. with STD code : _____

Signature of Witness : _____

Date : D D M M Y Y Y Y

Name & Designation : _____

Address : _____

_____

Tel. with STD code : _____

Signature of Employer : _____

Date : D D M M Y Y Y Y

Company Seal : _____

Note:- Witness should neither be a relative of the Life Assured nor a claimant under the policy.