

No. 4 Certificate of the Employer

This form should be filled up and signed by an authorized person in the organization under whom the deceased served.

Policy No. _____

On the life of _____

1. Particulars of the Deceased

(a) Name _____

(b) Residential Address _____

(c) Is the deceased the same person described in the above named policy as _____

2. Particulars Regarding Services

(a) Date of appointment _____

(b) Designation held at death _____

(c) Date of birth as per services record _____

(d) Date last attended duty _____

(e) Sick leave (more than 7 days on medical ground) availed of during the last three years.

From

To

Nature of Ailment

| <u>From</u> | <u>To</u> | <u>Nature of Ailment</u> |
|--------------------|------------------|---------------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

(f) Name & Address of the doctor who attended him/her and recommended him/her for leave.

3. Particulars Regarding Death

(a) Date of Death _____

(b) Place of Death _____

(c) Cause of Death _____

The undersigned hereby certify that the information given above is true to the best of my knowledge and belief.

Dated at _____ this _____ Day of _____

Name of Employer _____

Designation _____

Address (in full) _____

Contact Tel. No. _____

Signature of Employer _____

Declared at _____ this _____ Day of _____ 20 _____ before me

Signature & Seal _____

Designation _____

Address _____