SBI Life
Apne liye. Apno ke liye.

WITHOUT PREJUDICE

EMPLOYER'S CERTIFICATE (For Death Claim)

(a) Form to be filled in English only
(b) Kindly fill up the form complete in all respects and accompanied by certified copies of leave applications & Medical Certificates
(c) Kindly be legible in filling up the form and ensure all information is declared correctly and clearly. DO NOT leave any columns blank

Policy No. :

Name of the Life Assured (Employee):

Employee No. / ID /PF ID:

Date of Birth: D D M M Y Y Y Y

Nature of Age proof submitted:

Last/Current Designation:

Temporary/Permanent:

Date of joining service: D D M M Y Y Y Y

Nature of employment: ☐ Manual ☐ Skilled ☐ Unskilled ☐ Technical ☐ Clerical ☐ Supervisory
☐ Managerial ☐ Other. If other, Please specify: _____

Details of Physical/Mental disabilities of Employee, as per records _____

Date on which Deceased last attended Office D D M M Y Y Y Y

Reason for discontinuation of Employment, if applicable _____

Date of intimation of illness D D M M Y Y Y Y

Date of death D D M M Y Y Y Y

Leave Particulars

Please furnish particulars of leave availed on medical grounds by the deceased for last 5 financial years.

Note: *Please provide copies of the Medical Certificates/records provided by the Life Assured in support of the leave.

Dates		Reasons as per Medical Certificate/Leave application	Medical Certificated Submitted(Yes/No)*
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Did your Company conduct pre-employment medical check up on this employee

☐ Yes ☐ No (If Yes, please attach copy of the reports)

Did your company conduct any Medical health check –up on the employee anytime in the last 5 years

☐ Yes ☐ No (If Yes,please attach copy of the reports)

Was the Life Assured covered under any Medical Insurance OR Reimbursement Scheme ☐ Yes ☐ No

If yes, Please provide us the details of any medical disbursements/payments made to the Life Assured during the past 3 years along with copies of the medical certificates/records provided by the Life Assured.

Dates of illness	Particulars of illness and the details of Doctors /Hospitals where he was treated	Amount Disbursed

Signature of Authorized Signatory

Stamp of the organisation

Name:

Designation:

Address

Employer's Phone No.:

Date: D D M M Y Y Y Y

Place: