



EMPLOYER QUESTIONNAIRE

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|------------|--|-----------|--|
| Policy No. | | Claim No. | |
|------------|--|-----------|--|

1. LIFE ASSURED'S INFORMATION

| | | | |
|-----------------------------|--|---------------------------------------|--|
| Name of the Life Assured | | | |
| Address of the Life Assured | | | |
| Date of Birth | | | |
| Date of joining | | Date of resignation/Last date of Work | |
| Last designation held | | | |

2. DETAILS OF ILLNESS/DEATH

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|--|--|
| Date of intimation of illness/accident | |
| Symptoms complained of | |
| Date of Symptom/Accident | |
| Date of Death | |
| Who intimated the death of the deceased? | |
| Brief Details of Illness/Accident | |

3. LEAVE PARTICULARS

Leave particulars of the deceased for the period from _____ to _____

| Nature of leave | Dates of leave | Date of Joining | If Sick leave, Medical Certificate received or not (If yes, provide copy) |
|-----------------|----------------|-----------------|---|
| | | | |
| | | | |
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4. ANY OTHER INFORMATION

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5. EMPLOYER DECLARATION

I/We hereby declare that the above information has been verified by us to the best of our knowledge and belief.

| | | | |
|-------------------|-------|--------------------|-------|
| Name of Signatory | _____ | Company Name | _____ |
| Designation | _____ | Company Address | _____ |
| Signature | _____ | | _____ |
| Date | _____ | Company Seal/Stamp | _____ |