



## EMPLOYER QUESTIONNAIRE

### POLICY DETAILS

Policy number:

### DETAILS OF LIFE ASSURED

Name of Life Assured:  Mr.  Ms.  Mrs.

Father's / Husband's name:

Address of the Life Assured:

PIN Code:

Date of death:

Date of joining:

Last designation held:

Date of resignation / Last date of work:

Mediclaim record of the deceased for the last 5 years or since date of joining (whichever period is shorter)

S. No.	Date of Claim	Ailment	Claim Status (Settled / Not Settled)	Self / Family

Provide the leave record of the deceased for the past 5 years or since the date of joining (whichever period is shorter)

Nature of leave	Start date of leave	End date of leave	If sick leave, medical certificate received or not (If yes, provide copy)
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Any other relevant information related to sick leaves

### DECLARATION

I / We hereby declare that the information provided above is true and correct to the best to my personal knowledge & belief and nothing has been concealed therefrom.

Name of signatory:  Designation:

Name & address of company:

PIN Code:      Mobile / Telephone number:

Date:

Place:

Sign here

Signature

Seal / stamp here

Company seal / stamp:

Note: If you feel that the space provided is insufficient anywhere, kindly attach additional sheets