

CERTIFICATE BY EMPLOYER
(Format AJ)

Policy Number: _____

Date : _____

1. Details of the Employee (Life Assured):

Name:	
Employee Number / ID:	
Age on last working day (if applicable):	
Last / Current Designation:	
Temporary / permanent staff:	
Joining date:	
Date of confirmation:	
Nature of employment:	Manual / skilled / unskilled / technical / clerical / supervisory / managerial / other. If other, please specify
Last working date, if applicable:	
Reason for discontinuation of Employment, if applicable:	

2. Please give the details of the medical / sick leave taken in last 5 years. 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
From	To	

3. If the employee has availed of any medical benefits, please provide the following details:

Name of the Medical Benefit / Scheme	Amount claimed (Rs.)	Nature of treatment / illness / hospitalization	Date of claim

4. Did your company conduct pre – employment medical check up on this employee?

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

5. 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)

6. Details of other Life Insurance Policies / Health Insurance Policies / Mediclaim / Group Insurance Policies for which premium is deducted against salary:

Name of the Insurance Company	Policy number	Sum Assured (Rs.)	Riders Opted	Commencement date	Premium Amount (Rs.)

Signed at _____ this _____ day of _____ 20 ____.

Signature : _____

Name : _____

Designation : _____

Address : _____

Tel no : _____

Stamp of the Employer: