ADAMJEE LIFE ASSURANCE COMPANY LIMITED

EMPLOYER STATEMENT (DISABILITY)

Group Policy No. _____

Claim No._____

1. Name of the Employee (In Block Letters)	
2. Designation	
3. Personnel No./ Employee No.	
4. Date of Birth (Age)	
5. Salary/ Wages	
6. Date of appointment 7. Nature of Job 8. a. Status of employment at the time of injury	Permanent ☐ Contractual ☐ Confirmed / Regular Employee ☐ On leave ☐ Terminated ☐
b. Current Status of employment	Confirmed / Regular Employee ☐ On leave ☐ Terminated ☐
9. (a) Are you satisfied that the Employee's Statement made herein (form attached) is correct? (b) If not please state the inaccuracies.	
10. Sate the period of absence treated: (Due to accident)	From: To:
11. Has the Employee Returned to Work	Yes ☐ No ☐ If yes, date returned to work: _____
12. Amount of Insured	

I hereby certify that the above named employee is a member of our Group Disability Program. The Information stated above is correct to the best of my knowledge and belief.

Dated at _____ this _____ day of _____200

_____

Manager/ Incharge
Signature & Seal