

# CERTIFICATE OF EMPLOYER - CI CLAIM

Policy No  on the life of

## Section I

a) Name of the Life Assured :

b) Date of Birth :

c) Address of Life Assured :

d) Nature of Duties and designation :

e) Date of joining the service :

f) Last day (date) of attending duties :

## Section II

Was the Life Assured covered under any medical insurance policy or medical reimbursement scheme - Yes / No.

If yes, Please provide details of the same and of any disbursements made to the Life Assured by the employer under its medical reimbursement scheme during the past 3 years for each spell of illness

Period of illness		Particulars of illness	Amount Medical Expenses reimbursed
From	To		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

## Section III

Nature and Duration of leave granted to the Insured on each occasion (Please state nature of leave granted i.e. Casual leave, Earned/ Privilege leave, Sick leave etc.) during the last three years. If medical certificates were produced in support of the leave applications, please furnish copies of the leave applications and medical certificates.

Nature of Leave	Exact reason for availing leave	Period of Illness		Whether medical certificate Submitted?
		From	To	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Signature of Employer :

Name & Designation :

Address :

Date :

Tel. with STD code:   Company Seal :