

Certificate By Employer

Policy Number:

1. Name and address of the Company / Organisation: _____

2. Details of the Insured Employee:

a) Name in full: _____

b) Nature of employment & Designation as on date: _____

c) Date of joining service:

d) Annual Income for the past 5 Financial Years: _____

f) Date of Illness:

g) Cause of Illness: _____

3. Is there any medical benefit scheme for the employees in your office? If yes, please provide details of the scheme and also details, if the same were availed by the insured employee during the last one year.

4. Kindly give details of leave along with reasons for leave, availed by the insured employee for 5 consecutive days or more, over the last one year in the format appended below. (Please attach separate sheet if required)

From date	To date	No. of days	Type of Leave	Reasons for leave	Date of resumption of duties
<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"/> <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"/> <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"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

5. Currently is the Insured Employee at work: Yes No

If no, date since when he is on leave: _____

Reason for leave: _____

DECLARATION:

We hereby certify that the above information is true and correct as per the records maintained by the Company. We hereby provide consent to receive call from Aditya Birla Sun Life Insurance Company Limited (ABSLI) or its authorized Service Providers in connection with any matter related to this Policy.

Name of authorized signatory of the Company / Organisation: _____

Signature and stamp

Designation: _____

Date:

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Place: _____

FOR/1/17-18/1394

"The Trade Logo "Aditya Birla Capital" Displayed Above Is Owned By ADITYA BIRLA MANAGEMENT CORPORATION PRIVATE LIMITED (Trademark Owner) And Used By ADITYA BIRLA SUN LIFE INSURANCE COMPANY LIMITED (ABSLI) under the License."

Aditya Birla Sun Life Insurance Company Limited Registered Office: One World Centre, Tower 1, 16th Floor, Jupiter Mill Compound, 841, Senapati Bapat Marg, Elphinstone Road, Mumbai - 400 013. IRDAI Reg No.109 | CIN: U99999MH2000PLC128110 Toll free no. 1-800-270-7000 <https://lifeinsurance.adityabirlacapital.com>

