FORM NO 3787
CLAIM FORM "E"

भारतीय जीवन बीमा निगम
Life Insurance Corporation of India
Central Office, Mumbai

Divisional Office	Branch Office

CERTIFICATE BY EMPLOYER

In connection with claim under Policy No. on the life of (insert full name of the deceased) I hereby, make the following statement :

1. a. Name in full. b. Address of the deceased. c. Nature of Employment d. Date of Joining Service	
2. (a) Date on which the deceased last attended duties. (b) (i) On what date did deceased first complain of illness which caused his immediate absence before death and (ii) Symptoms complained of (c) Date of death (d) Who informed you of the death of the deceased ? (e) Approximate age of deceased at death.	Years

3. Record of absence from duty during the *period From To

Date of Leave From To	Nature of Leave Availed Casual or Privilege or Sick	Ground on which Leave Sought for	In the Case of Sick Leave whether Medical certificate Produced.

(N.B) : Please state nature of leave availed of Casual, privilege, Sick etc.. If on grounds of health, please state whether medical certificate was produced and if so, send copies of leave applications and certificates.

4. Is there any Medical Benefit Scheme for the employees in Your Office. If so, kindly give the particulars of the illness and treatment for which disbursements were made under the Scheme to the deceased.	**Period** **From To Particulars**

*This period should commence from three years prior to the date of commencement of risk/date of revival and end with the date of death. D.O's should indicate the period with reference to the particular policy before issuing the form.

Signature of Witness
Designation
Address

Signature of Employer
Designation
Address

Date

NOTE : The witness must not be a relative of the deceased nor a claimant under the policy. If the Certificate is signed in Vernacular by the Declarant the Witness is required to state below that the contents of the Certificate were explained to the Declarant in Vernacular and the gaps filled in at his dictation.