EMPLOYER'S PERMANENT HEALTH INSURANCE CLAIM FORM

Policy Number :
Name :

1. Employers Name and Address_____

2. Date of joining company: ___/___/___ Date of joining Scheme: ___/___/___

3. Is he employed on a full-time permanent basis? _____ **Yes/No**

4. If not please state nature of contract _____

5. Can you please supply precise details of Employee's duties, (if a job description is available, can you please attach a copy): _____
_____
_____

6. Nature of Disability: _____

7. What duties can the employee still perform?: _____
_____
_____

8. Normal retirement age _____ Start of continuous absence:____/____/____

9. Basic Annual Salary at date of continuous absence: _____

DECLARATION

We declare that the above statements are true and complete, that the above named employee has not returned to work since the date of commencement of absence and that the sole reason for this absence has been the disability specified above.

Signature: _____ **Staff Title: _____**

Date _____ **Company Stamp**