EMPLOYER'S CERTIFICATE (FORM "D")

(To be completed by the last Employer of the Deceased)



GUIDELINES FOR COMPLETION OF THE FORM

- 1. Please complete the form in all respects. Do not leave any column blank or incomplete. Please provide details. Use seperate sheets if required.
- 2. Where boxes have been provided to facilitate your reply, please only tick the relevant box. Leave the remaining boxes unmarked.
- 3. Please write in neat legible script. Do not use abbreviations, dots, crosses and dashes. Do not overwrite, mutilate, cancel, or delete. In case inadvertently, an error has occurred, then please correct neatly under your full signature.
- 4. Please sign this form in the same signature & style that you affixed on your CNIC. In case your signature now differs then please provide a set each of three specimen signature in both styles duly attested by the witness / attestor of this form.
 5. This form along with any other form / document required to be completed & submitted to the Company should be delivered directly to the Head Office of
- 5. This form along with any other form / document required to be completed & submitted to the Company should be delivered directly to the Head Office of the Company at the address mentioned at the bottom of this form. The Company shall not be responsible for any form that is not received by it at the Head Office of the Company.

	Policy Owner:
fe Assured:	
	CERTIFICATE BY EMPLOYER
/ We	(Full Name of the Industrial Unit / Business Unit / Firm / Organization / Department in which the Deceased worked)
ocated at	dustrial Unit / Business Unit / Firm / Organization / Department in which the Deceased worked)
o hereby solemnly affirm and	declare that Mr./Ms./Mrs.
/o / w/o	& bearer of CNIC No: single female deceased / Husband's name for married female deceased) (Computerized National Identity Number of the D
vas employed with us for	(Complete Residential Address including specific Locality in City / Town / Village of the Deceased years prior to his / her death, and that He / She diec
allowing place	on the day of in the year
residence/w His / Her age at death was	workplace/Hospital / Clinic) (Date) ((month) ((year)) years. He / She died as a consequence of (The physical or mental, illness / disability / injury / medical condition since the physical or mental illness / disability / deformity / injury / medical condition since the physical or mental illness / disability / deformity / injury / medical condition since the physical or mental illness / disability / deformity / injury / medical condition since the physical or mental illness / disability / deformity / injury / medical condition since the physical or mental illness / disability / deformity / injury / medical condition since the physical or mental illness / disability / deformity / injury / medical condition since the physical or mental illness / disability / deformity / injury / medical condition since the physical or mental illness / disability / deformity / injury / medical condition since the physical or mental illness / disability / deformity / injury / medical condition since the physical or mental illness / disability / deformity / injury / medical condition since the physical or mental illness / disability / deformity / injury / medical condition since the physical or mental illness / disability / deformity / injury / medical condition since the physical or mental illness / disability / deformity / injury / medical condition since the physical or mental illness / disability / deformity / injury / medical condition since the physical or mental illness / disability / deformity / injury / medical condition since the physical or mental illness / disability / deformity / injury / medical condition where the physical or mental illness / disability / deformity / injury / medical condition where / injur
he Deceased was suffering fro	(The physical or mental, illness / disability / injury / medical condition that come the above mentioned physical or mental, illness / disability / deformity / injury / medical condition since
9	years month days.
His / Her Date of Birth as per :	Service Record is
He / She last attended work o	(date) (month) (year)
lis / Her Occupation / Work	
'	 (Nature of duties & details of work performed) & Marks of Identification were as follows:
he complete leave record of th	he deceased (Use seperate sheet if required)
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I confirm that $Mr./N$	Лs./Mrs	is the same person as described in the					
Policy No:		issued by New Jubilee Life Insurance Company Limited on					
Dated at	(place)	this	(date)	day of	20	(year)	
0	· ·	*		9		SS	
Full Name of Signatory				Name of Attestor / Witness			
CNIC No.				CNIC No			
Address of Employe	r:						
	information requested he available with the Employe with copies of Medical ce official of Jubilee Life Insur Assistant Manager or by ar				om the personal of the Decease This Form is to be signation not be of Pakistan or of	ed Official of the Employer . All knowledge of and information of may please be provided along be witnessed and attested by an elow Assistant Branch Manager / the Government of any province t a clear legible copy of his / her	