MetLife

EMPLOYERS STATEMENT

This statement must be completed by the employer, or his duly authorized agent,. It must not be completed by a clerk nor by any Agent of MetLife.

FULL NAME OF INSURED

……

SOCIAL SECURITY NUMBER……IDENTITY CARD NUMBER ……

NAME AND BUSINESS ADDRESS OF INSUREDS EMPLOYER…….....

……

DESCRIBE THE CIRCUMSTANCE OF ACCIDENT IF SUCH HAS HAPPENED AS A RESULT OF HIS OCCUPATION DUTIES OR WHILE AT WORK ……

WHEN WAS INSURED CMPLEED TO GIVE UP HIS DUTIES (EXACT DATE) ……..

WHEN DID INSURED RETURN TO WORK ……

HAS INSURED BEEN ABLE TO PERFORM PART OF HIS DUTIES DURING THE PERIOD OF THE DISABILITY

……

DESCRIPE EXACT DUTIES OF INSURED ……

WHAT THE MONTHLY GROSS SALARY OF INSURED € …….

HAVE YOU PAID ANY SALARY TO INSURED DURING THE PERIOD OF THE DISABILITY?

……

HAVE YOU SUBMITTED A REQUEST FOR PAYMENT FROM THE SOCIAL SECURITY FUND DURING THE PERIOD OF THE DISABILITY OF INSURED? ……..

WHAS INSUREDS INJURY THE SOLE CASUE OF HIS/HER ABSENCE FROM DUTY FOR ALL OF THE ABOVE PERIOD? If not, give details. .

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DECLARATION

Full name of Employer:…….. Signature of Insured:……..……

Title of Employer ……..:……

Seal and Signature: Date …….. ……...

……..

……..

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