



**STATE LIFE**  
**INSURANCE CORPORATION OF PAKISTAN**  
 Registered & Supervised by the Securities  
 & Exchange Commission of Pakistan  
**KARACHI SOUTHERN ZONE**

Telephones: 021-99217001-20  
 Ext. : 3122  
 Direct : 021-99217039  
 Fax : 021-99217025

## Claim Form D

### Certificate of Employer

Policy No: \_\_\_\_\_ Name of the Claimant: \_\_\_\_\_

**Instructions for completion of this form:**

- ◆ This form is to be completed by employer of the deceased life insured.
- ◆ Please provide complete information. Incomplete and blank form will not be entertained.
- ◆ Please fill in the form with clear and legible handwriting and avoid cutting and overwriting.

I / We \_\_\_\_\_ do hereby declare that  
 Mr/ Mrs/ Ms \_\_\_\_\_ son/daughter/wife of \_\_\_\_\_  
 was employed with us for \_\_\_\_\_ years \_\_\_\_\_ months at \_\_\_\_\_. He/She last attended  
 business (this office) on \_\_\_\_\_ and died at age of \_\_\_\_\_ years at \_\_\_\_\_ on  
 \_\_\_\_\_ after suffering from \_\_\_\_\_ for \_\_\_\_\_ years \_\_\_\_\_ months  
 \_\_\_\_\_ days. His/Her personal appearance was as follows: \_\_\_\_\_

His/Her date of birth as per service record is \_\_\_\_\_ A copy of his age proof submitted with us is enclosed:

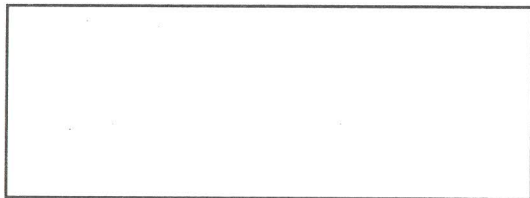
As per our record, the above named person availed of the following leaves years prior to his/her death:	
From:	To:
Period	Reasons for leave mentioned in the application
From to	
From to	
From to	
From to	

Copies of the leave application and medical certificates provided in support are attached.

I am /we are fully satisfied that he/ she is the same person described in the policy issued by the State Life Insurance Corporation of Pakistan as the insured.

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 201 \_\_\_\_\_

Official seal of the Company



(Signature of the authorized officer)

Name \_\_\_\_\_  
 Designation: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 vPhoneNo. \_\_\_\_\_  
 Fax No: \_\_\_\_\_

**Attestation:**

The statement below must be signed by a Gazetted Officer, Chief Executive Officer of Municipality, Justice of Peace, Magistrate, Collector or Judge of the Place or district where the death took place or officer of State Life (not below the rank of Assistant Manager on the administrative side or Area Manager on Marketing side), if he or she knows the claimant.

I certify that the information provided in this form is complete to the best of my knowledge and belief.

Signature with seal: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone No: \_\_\_\_\_ Fax No: \_\_\_\_\_ CNIC No: \_\_\_\_\_