Sagicor

EMPLOYERS STATEMENT
DISABILITY BENEFIT

This Statement must be completed by the employer, or his duly authorized agent. It must not be completed by a Clerk, Bookkeeper or Foreman, unless specially authorized, nor by any Agent or employee of Sagicor Life Inc.

Name of Life Insured:
Date of Birth:
Name and Business Address of Insured's Employer:
Description of injury or illness resulting in Insured's absence from employment:
Was injury caused by reason of occupation? Yes ☐ No ☐
State the exact date Insured was compelled to give up his duties:
State the exact date Insured returned to work:
Describe Insured's duties:
Was there a period of time during which Insured could only perform part of his occupational duties: (Give exact dates)
Was Insured's injury or illness the sole cause of his absence from duty for all of the above period? If not, give particulars:

I hereby declare that the above information is true and complete.

_____ Date

_____ Signature and Company's Stamp

_____ Title

_____ Witness