

F. NOTICE OF INVALIDITY DETAILS

F1. Description Of Morbidity

F2. The Year Morbidity Is First Suffered

F3. Is The Insured Person Still Engaged In Employment? Yes No

F4. Date Of Cessation of Employment (If Applicable)

Day Month Year

F5. Employment Information

No.	Employer's Name & Address	Period Of Employment	Designation / Occupation

Please attach the Medical Report In PERKESO Format [Reg. 46(ii)]

G. NOTICE OF DEATH DETAILS

G1. Date Of Death

Day Month Year

G2. Time Of Death Work-Related Non-Work-Related

G3. Is The Death Due To Accident? Yes No
(If 'Yes', Please complete D : NOTICE OF ACCIDENT DETAILS)

G4. Status Of Insured Person Single Married Divorced
(At the time of death)

H. PREFERRED PERKESO OFFICE FOR DEALINGS

City

State

I. EMPLOYER'S DECLARATION

I hereby certify to the best of my knowledge and belief that all particulars given are true; and
(Please tick on the relevant box)

- Certifies that the insured person is an employee of this company.
- Certifies that the insured person is an employee of this company and was on unpaid leave at the time of the accident.
- Certified that the insured person is an employee of this company and has suffered a serious disability.

Signature Of Employer :

Full Name :

Designation :

Official Company Stamp

Date

Day Month Year

No signature is required if the submission of this form is via online

