CNP CYPRIALIFE
Registr.No. .46532 – Private
17, Acropoleos Str., 2006 Strovolos
Tel. 22 11 12 13

Policy Number:

EMPLOYER'S DECLARATION

If the insured person is self-employed, there is no need to complete this declaration.

This declaration must be completed by the employer or an employee authorized by him.

Under NO circumstance may this be completed by the Insurance Intermediary of CNP Cyprialife or by the Insured Person.

Name of Insured Person ……….

Social Security No. …………………………………………………………… Identity Card No. ……….……………………………

Name, address and telephone number of Employer ……………………………..……………………………………………….

……

1. For what reason was he/she obliged to leave his/her work? ………………………………………………………….

   ………

   ………

2. When did this occur? Give exact date …………………………………………………………………………………………….

3. When did/will he/she return to work? ……………………………………………………………………………………….

4. Was the only reason for his/her absence from work during the above period, the reason stated in paragraph 1? If not, give details ……………………………………………………………………………………………….

   ………

5. Describe his/her duties …….

   ………

6. Was there a period in which he/she performed only parts of his/her duties? Give exact dates.

   ………

7. What is his/her gross monthly income? ………………………………………………………………………………….

8. Was there an application submitted or was any form of payment made, from another fund, during his/her disability period? ……………………………………………………………………………………………………

   ………

9. Has he/she been absent from his/her work during the past 12 months? If yes, give details of the reasons and dates of absence. ……………………………………………………………………………………………

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10. a) Was there a change in his/her duties within your company due to health reasons? □ Yes □ No

b) Give details ………

c) When did this change occur? Give exact date ………………………………………………………………………………

INFORMATION

In the context of providing insurance services, CNP CYPRIALIFE LTD (the «Company») intends to collect and process the personal data that concern you and which are included in this form.

When the Company collects and processes personal data, it ensures that this is carried out in a legitimate manner and that all necessary measures are taken in order to ensure their safety.

DECLARATION

I solemnly declare and in full awareness of the consequences of the Law regarding false statements that my statements set out above are true, complete and accurate. I also declare that I have informed the person whose details are contained in this Claim regarding the provision of his/her personal data by me to the Company.

Employer's stamp (if applicable):

Address ………………………………………………………………………………

Full Name ……………………………………………………………………………..

Position ………………………………………………………………………………..

Signature ……………………………………………………………………………… Date ……../………/………