



Financial Insurance Company Limited  
Financial Assurance Company Limited  
(each part of AXA)  
P.O. Box 602, Shannon, Co. Clare

# Employer's Statement

Part A : To be completed by Policyholder  
Part B & C : To be completed by Employer

## Part A : Personal Details *(To be completed by Policyholder)*

Full Name:			
Address:			
Date of Birth:		Finance Provider:	
Claim Number:		Policy Number:	

## Part B : Information on Employment *(To be completed by Employer)*

Start date of employment			
Hours worked per week			
Occupation			
Date employee last worked			
Date employee was first away from work because of sickness			
Date returned to work Or Period the employee is expected to be away from work due to sickness/accident.	Weeks/months		
Nature of sickness			
Is the person still employed by you?	Yes		No
Was the employee working outside the Republic of Ireland?	Yes		No
If 'Yes', please give dates	From		To
What country was the employee working in?			

## Other Relevant Information

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## Part C : Employer's Information *(To be completed by Employer)*

Print Name:			
Position:			
Telephone Number:		Fax Number:	

<b>Company Name &amp; Address</b>	<b>Company Stamp</b> (if you do not have a company stamp please provide a copy of the termination letter sent to employee)
<b>Signature:</b>	<b>Date:</b>