

GOOD HEALTH CERTIFICATE

I have examined Sh./Smt. on and found him/her be in continuous good health.

Signature of Insurnat

Signature of Medical Officer

Place.....

Name

Date

Designation rubber stamp

FORM IF STATEMENT OF RESPECTABLE PERSON

1. I hereby certify that Sh./Smt. holder of Policy No. is personally known to us for theyears and that there has been no adverse change in personal or family history or occupation of insurant. The insurant is not related to me.

Signature.....

Date

Occupation & Address.....

2. I hereby certify that Sh./Smt. holder of Policy No. is personally known to us for theyears and that there has been no adverse change in personal or family history or occupation of insurant. The insurant is not related to me.

Signature.....

Date

Occupation & Address.....