



**Accident Benefits Claim**

**Employer's Statment**

This statement must be completed by the employer, or his duly authorized agent, such as a Superintendent, Paymaster, etc, It MUST NOT be copmleted by a Clerk, Bookkeeper or Foreman, unless specially authorized, nor by any Agent of MetLife.

1. Full Name Of Insured : .....

2. Name and business address of Insureds' employer .....

3 .When Was Insured compelled to give up his duties? ( Give exact date : ) .....

4 . When did Insured return to work? .....

5 . Was Insured's injury the sole cause of his absence from dury for all of th eabove period?

Ifnot give particulars . : .....

Date : .....	Seal & Signature : .....
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Witness : .....	Title : .....
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