

Benefit Payment Form

Policy Holder:	
Subsidiary Name(if Any):	
Policy No:	
Policy Commencement Date:	

Member Details:

Name of Employee	
Employee Code	
Gender	
Date of Birth	
Date of Joining the Service	
Last Date of Attendance to work	
Total No. of Years of Service in the Company	
Reason for Leaving the Company	Death <input type="checkbox"/> Resignation <input type="checkbox"/> Retirement <input type="checkbox"/> Permanent total disablement <input type="checkbox"/> Others <input type="checkbox"/>
Is Eligible for Gratuity as per the Trust Rule	Yes <input type="checkbox"/> No <input type="checkbox"/>
Last Designation/Grade	
Last Drawn Monthly Basic Salary for Gratuity Calculation	
If Yes, Then Amount Payable (INR)	

Trustee's Declaration

I/We hereby declare that the above information has been verified by us to the best of our knowledge and belief. I/We also undertake to make the final settlement of the Payment to the member and that any litigation or controversies arising shall be handled by us.

We confirm that we are claiming the Gratuity amount for the above mentioned member only from Generali Central Life Insurance Company Limited and not from any other insurer.

Name of the Employer _____

Name of the Trust _____

Name of Trustee: _____ Signature: _____ Date: _____

Name of Trustee: _____ Signature: _____ Date: _____

Name of Trustee: _____ Signature: _____ Date: _____

Address: _____

Affix the Company Rubber Stamp/Seal _____