MEDICLAIM INSURANCE POLICY PROPOSAL

(Pre Existing Disease/Injury to be Excluded under the Policy)

(To be competed by Each Employee/Member in respect of himself/herself/and his/her eligible Family Members Proposed to be covered).

1. Details of Employees/Member including Family Member Proposed for Insurance

S.N.	Name of the Employee Members and Eligible Family Members	Date of Birth	Sex	Occup-ation	Relation-ship to the Employee	Basic Pay	Details of any knowledge of any positive existence or presence or any ailment sickness or injury which may require medical attention immediate future and/or details of any ailment, sickness or injury which had been treated during the preceding 12 months
A.							
B.							
C.							
D.							
E.							
F.							
G.							

2. Are you suffering/suffered from diabetes/hypertension/chest pain or coronary insufficiency or nycoardial infaction? If so, complete the Annexed Questionnaires.

3. Residential Address of the Employee/Members _____

_____

_____

4. a) Name and Address of Family Doctor, including telephone number, if any ;-

b) Doctor Registration Number : _____ State/U.T. _____

5. Sum Insured as per the pay scale :

All the statements made above and the answers given on my behalf and on behalf of the family members are wholly true and correct to the best of my knowledge and belief. I have disclosed all particulars materials to the risk. It is hereby understood and agreed that the statements, answers and particulars are basis on which the insurance is being guaranteed. If after the insurance is effected, it is found that the statements answers or particulars are incorrect of untrue in any respect, the company shall have no liability under this Insurance in respect of myself and my family members proposed for insurance.

Place : _____

Date : _____

Signature of the employee/member for himself/herself and/or on behalf of other family members to be covered

WITNESS