**MEDICAL INSURANCE FORM**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | | | | | | | |
| **Name of Employee** | | **:** |  | | | | | **Employee ID** | | | **:** |  | |
| **Designation** | | **:** |  | | | | | **Department/Section** | | | **:** |  | |
| **Date of Joining** | | **:** |  | | | | | **Nature of employment** | | | **:** |  | |
| **Mobile Number** | | **:** |  | | | | |  | | |  | | |
| I, Dr./Mr./Ms.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_hereby declare that my parents/children as under are fully dependent on me. | | | | | | | | | | | | | |
| **Details of Employee and members to be covered** (*Refer Institute Circular*) | | | | | | | | | | | | | |
| **SN** | **Name of the Employee & Members to be Covered** | | | | | **Date of Birth (DD/MM/YY)** | **Age as on**  **29.06.20** | | **Gender (M/F)** | **Occupation** | | | **Relationship with Employee** |
| **1** |  | | | | |  |  | |  |  | | |  |
| **2** |  | | | | |  |  | |  |  | | |  |
| **3** |  | | | | |  |  | |  |  | | |  |
| **4** |  | | | | |  |  | |  |  | | |  |
| ***Additional members to be covered on a payment basis*** *(Refer Institute Circular)* | | | | | | | | | | | | | |
| **SN** | **Additional Members**  **to be Covered** | | | | | **Date of Birth (DD/MM/YY)** | **Age as on**  **29.06.20** | | **Gender (M/F)** | **Occupation** | | | **Relationship with Employee** |
| **1** |  | | | | |  |  | |  |  | | |  |
| **2** |  | | | | |  |  | |  |  | | |  |
| **Residential Address** | | | | **:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
|  | | | |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| **Family Doctor**  (Name, Mobile Number) | | | | **:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| *I would like to cover them under the* ***Thapar Institute Group Medical Insurance Policy*** *for the period from\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* to *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*.  I fully understand that as per the policy coverage my parents are covered only till attaining the age of 80 years. My parents are not in employment. I understand that in case my mother is a widow and/or dependent, then she is not availing a similar hospitalization benefit from another source.  I further state that none of the children mentioned above (both under premium borne by Institute or by me) are above the age of 26 years as on 29th June 20 .  I also understand that only a total of 4 members can be covered under this policy and if this number is exceeded, then I will bear the additional premium as will be decided by the Institute.  I understand that on the basis of the information provided by me, this insurance is guaranteed. If after the insurance commences, it is found that the statements answers or particulars are incorrect or untrue in any respect, the company shall have no liability under this Insurance in respect of myself and my family members proposed for insurance. | | | | | | | | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date :** |  |  | **Signature :** |  |
| **Place :** |  |  | **Name :** |  |

To Whomsoever It May Concern



This is to certify that Dr./Mr./Ms. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_spouse of

Dr./Mr./Ms. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_is working in our organization (Name of Organization:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) since \_\_\_\_\_\_\_\_\_ (dd/mm/yy) as\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

This is to further certify that he/she is covered/not covered under the Institute Group Medical Insurance Scheme.

|  |  |
| --- | --- |
| **Name:** |  |
| **Designation:** |  |
| **Date:** |  |