THE NEW INDIA ASSURANCE CO.LTD.

HEAD OFFICE: 87, M.G.ROAD, FORT, MUMBAI-400001

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Staff Group Mediclaim Policy Enrollment Form for Active Employees and Retired Employees, as per modified revised terms w.e.f. 1st April 2020.

Name Mr./Mrs/Ms._____

S.R.No._____ Dept./Office _____

Residential Address : _____

_____

_____

Contact No._____ Email _____

Basic Salary as on date _____

Basic From (in ₹)	Basic To (in ₹)	Eligible Sum Insured
1	43299	500000
43300	55335	600000
55336	And above	1000000

1. **Eligible Sum Insured as per current Basic ₹ _____**
2. **Opted Higher Sum Insured ₹ _____**

(Signature of the employee)

Details of Persons to be enrolled

Srl.No.	Name of Person	Relation	Date of Birth	Dependent / Non Dependent	Pre-Existing Diseases, if any please give details
1					
2					
3					
4					
5					
6					
7					
8					
9					

(Please affix photographs of family members in spaces provided below)

1	2	3	4	5

6	7	8	9	10

Whether any person is covered under any other Medical Scheme / Policy Yes / NO.
If yes , give detail

Declaration

1. **I have read all the terms, conditions, exclusions and scope of proposed cover under modified revised Staff Group Mediclaim Policy on Floater Basis.**

2. **I , the undersigned hereby declare that my _____ (Relation), Mr./Mrs./Ms._____ age _____ years will be nominee in respect of this scheme with _____(%) share (In case, the nominee /s is /are minor, please provide the details of the Guardian).**

3. **I hereby authorize Company to deduct the applicable premium and Service Tax from my Salary per month towards the above scheme based on the details furnished by me.**

4. **I hereby declare that the above mentioned dependent family member/s is/are fully dependent (financially) on me. Their income is not more than ₹ 10,000/- per month**.(Income criteria will not be applicable for non-dependent family members)

5. **I, the undersigned also hereby confirm that the above details furnished by me are true to the best of my knowledge and if found otherwise, the Company shall have all the rights and authority to take necessary disciplinary action against me.**

(SIGNATURE OF THE EMPLOYEE)

Name :-_____

S.R.No.:-_____
Date:- _____

(SIGNATURE & SEAL OF RECEIVER)

Name :-_____

S.R.No.:-_____

Date:-_____

Acknowledgement of Enrollment Form

(To be filled in by Mediclaim Manager/Nodal Officer & given as receipt of enrollment form to employee)

We received duly signed Staff GMC Enrollment form from Mr/Mrs/Miss . . . . . .

S.R.No.. . . . . for policy period 20….. -20…. on day . . . . of …… (month). . . . . year covering. .

. . . . . (no.of) family members.

(SIGNATURE & SEAL OF RECEIVER)

Name :_____

S.R.No.:-_____

Date.:-_____