Details of Employee's Self and Family Coverage under Group Mediclaim Policy

Please read the instruction carefully before filling up the form

- Please use **CAPITAL LETTERS** letters only
- Please do not make any alterations / deletions / corrections on the form; use a new form instead.
- Registration Number is a mandatory field
- In case of incomplete details of dependants, enrollment will not be considered

Employee Details:

Full Name of Employee _____ _____

Registration Code _____

Designation _____

Gender (Male / Female) _____

Date of Birth (DD / MM /YYYY) _____

Date of Joining (DD / MM / YYYY) _____

Dependant's Details:

Spouse Name _____

Date of Birth (DD / MM / YYYY) _____

Child Name - 1 _____

Son/ Daughter _____

Date of Birth (DD /MM / YYYY) _____

Child Name - 2 _____

Son/ Daughter _____

Date of Birth (DD /MM / YYYY) _____

Father's Name _____

Date of Birth (DD / MM / YYYY) _____

Mother's Name _____

Date of Birth (DD / MM / YYYY) _____

I hereby declare that the information furnished above is true and correct to the best of my knowledge. If at any point of time it is found that statement or particulars given above are incorrect, BRLPS shall have no liabiltiy under this insurance in respect of myself and my family members proposed for insurance.

Place:

Date:

Supervisor's Name :----------

Employee's Name :----------

Signature :----------

Signature :----------