

Registration Form for Health Plan / Health Plan Plus

Agency Code

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Regn No. allotted

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Affix your passport size photograph

Personal Details

Applicant's Full Name			
Father's / Husband's Name			
Date of Birth		Sex	M <input type="checkbox"/> F <input type="checkbox"/>
Educational Qualifications			
Address			
Pin Code		Phone(R)	
Occupation		Phone(O)	
E-mail		Mobile	
Do you suffer from any disease, illness or injury? If yes, please give details			
Nominee		Relationship	

Options :

- Health Plan Annual Charges Rs 1950/-
- Health Plan Plus Annual Charges Rs 2950/-

Declaration

I hereby declare and warrant that the above statements are true and complete. I further declare that in case the Insurance Company does not settle the claim in full or partially to the hospital due to any reasons, the undersigned shall be liable to pay the dues, if any, to the panel hospital where he has undergone the medical treatment.

I further declare that I have read and understood the rules and regulations and I am willing to accept the coverage subject to the terms and conditions and exceptions prescribed by the company therein.

Place:

Date

Signature of the applicant