ANNEXURE - 'E'

THE ORIENTAL INSURANCE COMPANY LIMITED
HEAD OFFICE, NEW DELHI

OPTION FORM – STAFF GROUP MEDICLAIM POLICY

Name: Mr./Mrs.	
S.R. No.	
Deptt./Office	
Basic Salary as on 1st April (in case of serving employees)	
Basic Salary as on date of Retirement (for retired employees)	
Date of Retirement	
Mobile/Landline No.	
E-mail address	
Present mailing address	

Basic Salary	**Eligible Sum Insured**
less than Rs. 43,300/-	Rs. 5 Lacs
between Rs.43,300/- & Rs.55,335/-	Rs. 6 Lacs
greater than Rs. 55,335/-	Rs. 10 Lacs

CHOICE OF AVAILABLE OPTIONAL SUM INSURED (TICK CHOICE) Rs.

6 lacs	8 lacs	10 lacs	12 lacs	15 lacs	20 lacs	25 lacs
30 lacs	35 lacs	40 lacs	50 lacs			

S. No.	Name of Family Member	Relationship	Date of Birth	Dependent or Non-dependent	If Non-dependent, (income per month)	Whether covered under any other Medical Scheme? (Yes/No)
1		Self				
2						
3						
4						
5						
6						

Nomination:

I, the undersigned, hereby declare that Mr./Ms.___________________________ , ____________ (relation), aged _________ years will be nominee (in case, the nominee(s)/s is/are minor, please provide the details of the guardians).

Declaration for Dependency

I hereby declare / confirm that the above covered dependent child/ children/ dependent parents/ parents-in-law are fully dependent on me, as per guidelines (as applicable from time to time) under the Mediclaim policy.

Declaration

1. I have read all the terms, conditions, exclusions and scope of cover under the modified revised Group Mediclaim Policy on Floater basis.
2. I understand that the floater sum insured is applicable under Staff Group Mediclaim Policy.
3. I was not covered under the Group Mediclaim Policy earlier and now opt for coverage for self and following Dependent / Non-dependent family members of my family (for existing employees only).
4. 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 rights and authority to take necessary disciplinary action against me.
5. **For SERVING EMPLOYEES ONLY**: I hereby authorize the 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.

SIGNATURE___________________________

NAME_______________________________

Date________________________________

THE ORIENTAL INSURANCE COMPANY LIMITED
HEAD OFFICE, NEW DELHI

STAFF GROUP MEDICLAIM POLICY

PHOTO + DETAILS OF EMPLOYEE AND FAMILY MEMBERS

Employee Name: Emp.No. D.O.B	Recent Stamp size photograph
Family Member's Name: Relationship: D.O.B.	Recent Stamp size photograph
Family Member's Name: Relationship: D.O.B.	Recent Stamp size photograph
Family Member's Name: Relationship: D.O.B.	Recent Stamp size photograph
Family Member's Name: Relationship: D.O.B.	Recent Stamp size photograph

PLACE :
DATE :

Signature of the Employee