MSCI

ENROLLMENT FORM

DECLARATION FORM FOR MSCI GROUP MEDICLAIM SCHEME

(Please note: Parents and Siblings are not covered under Group Health Insurance Policy)

EMPLOYEE ID _____ EMPLOYEE NAME: Rushikesh Tummod DEPARTMENT: _____

LOCATION: _____

I WISH TO NOMINATE THE FOLLOWING DEPENDANTS UNDER THE MSCI GROUP MEDICLAIM SCHEME.

THE DETAILS ARE FURNISHED AS UNDER:

	NAME	DATE OF BIRTH	GENDER	RELATION WITH EMPLOYEE	PLACE OF POSTING	DESIGNATION	DETAILS OF EXISTING DISEASE IF ANY
EMPLOYEE	Rushikesh Tummod	4/7/99	Male				
SPOUSE							
CHILD 1							
CHILD 2							

I FURTHER DECLARE THAT THE ABOVE INFORMATION IS TRUE AND TO THE BEST OF MY KNOWLEDGE

Signature Rushikesh Tummod Date 7/18/24