

ENROLLMENT FORM

DECLARATION FORM FOR MSCl GROUP MEDICLAIM SCHEME

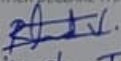
(Please note: Parents and Siblings are not covered under Group Health Insurance Policy)

EMPLOYEE ID _____ EMPLOYEE NAME: Rushikesh DEPARTMENT: _____
LOCATION: _____ Tummod

I WISH TO NOMINATE THE FOLLOWING DEPENDANTS UNDER THE MSCl 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	<u>Rushikesh Tummod</u>	<u>4/7/99</u>	<u>male</u>				
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