GALLOWAY'S
INSURANCE CONSULTANCY AGENCIES

GROUP MEDICAL INSURANCE FORM

No.	Employee Name	Number of Employees	Nuclear Formation (Spouse & Children)	Job Category	Inpatient Limits	Outpatient Limits	Age	Dental Limits	Optical Limits
1									
2									
3									
4									
5									

CONSENT

I consent to the collection and use of the information provided in this form by Galloways for the purpose of processing and administering the group medical insurance cover. I understand that my information will be kept confidential and used solely for insurance purposes.

Signature of Employee: .....
Date: .....

DECLARATION BY CUSTOMER

I hereby declare that the above information is true and correct to the best of my knowledge.

- **Company Name:** Galloways
- **Authorized Signatory:** .....
- **Date:** .....