

THE NEW INDIA ASSURANCE COMPANY LIMITED
Registered & Head Office: 87, M.G. Road, Fort, Mumbai- 400 001.

SWAVLAMBAN HEALTH INSURANCE SCHEME

GROUP MEDICLAIM POLICY FOR PERSONS WITH DISABILITIES OF THE
TRUST FUND FOR EMPOWERMENT OF PERSONS WITH DISABILITIES

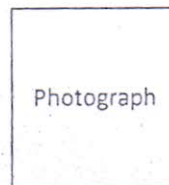
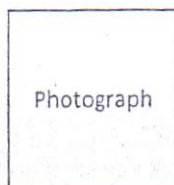
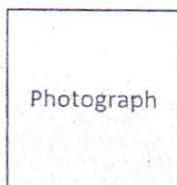
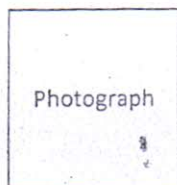
1. Name of Institute: _____

2. Camp Location: _____ Date: _____

3. DETAILS OF PERSONS TO BE INSURED:

S No	Name	Relation	Sex (M/F)	DOB
1.		PwD		
2.		Spouse		
3.		Child 1		
4.		Child 2		

PHOTOGRAPHS OF INSURED PERSONS:



4. Name of the Parents/Guardian: _____

(in case of minor)

5. Residential Address: _____

6. Average Annual Income: _____ Pan No. _____

7. Referred by (Institute Name): _____

8. Type of Disability: _____

9. Proposed Period of Insurance :- From _____ to _____

10. Declaration: I declare that the persons proposed for insurance are my family members and I also declare that

- i. My Annual Income is less than Rs. 3,00,000 per annum.
- ii. Persons proposed for this policy do not have any other Health Insurance Policy from any Insurer or any other entity.
- iii. The above statements, answers and/or particulars given by me are true and complete in all respects to the best of my knowledge.

Signature / Thumb Impression

Date:

Place:

DECLARATION FROM THE INSTITUTE

I declare that Mr./Ms. _____
has the disability as mentioned in point no. 8 above.

Authorized signatory with stamp

Date: