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:

Photograph	Photograph	Photograph	Photograph

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: