**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:

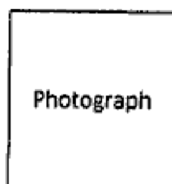
______________________________________________

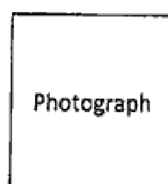
2. Camp Location: ______________________ Date: __________

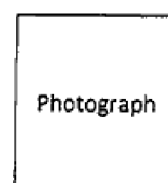
3. **DETAILS OF PERSONS TO BE INSURED:**

| 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:**

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**DECLARATION FROM THE INSTITUTE**

I declare that Mr./Ms.________________________________________

has the disability as mentioned in point no. 8 above.

Authorized signatory with stamp

**Date:**