THE NEW INDIA ASSURANCE CO. LTD.

Registered & Head Office: 87, M.G. Road, Fort, Mumbai- 400 001.

SWAVLAMBAN HEALTH INSURANCE SCHEME

NEW INDIA FLEXI FLOATER GROUP MEDICLAIM POLICY FOR PERSON WITH DISABILITIES OF THE TRUST FUND FOR EMPOWERMENT OF PERSON WITH DISABILITY

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 Guardian: _____ (in case of minor)
5. Residential Address: _____
   _____
   Tel No.: _____ E-mail: _____
6. Average Annual Income: _____ Pan No._____
7. Referred by (Institute Name): _____
8. Type of Disability: _____
9. **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 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: