

**Annexure B**

**OPTION FORM FOR INCREASE IN SUM INSURED**

I, alongwith my family members, who have already been covered under our Group Mediclaim Policy as per rules, opt for the increase in Sum Insured in terms of C.O. Circular No. ZD/1003/ASP/2002 dated September 4, 2002 w.s.f. \_\_\_\_\_

I, further certify that I have carefully gone through and understood the contents of this circular and shall abide by all the provisions of this circular and any subsequent modifications in terms and conditions in this regard.

I confirm that this option is irrevocable i.e., cannot be revoked by me.

Witness: _____	Signature of the Employee/Retired Employee _____
Signature: _____	Name of the Employee/Retired Employee _____
Name : _____	Salary Roll No. : _____
Address: _____	Name of the Office : _____
	_____
	_____
Date : _____	Date : _____
Place : _____	Place : _____

**(FOR OFFICE USE ONLY)**

1. Existing basic Sum Insured of the employee/retired employee Rs. \_\_\_\_\_
2. No. of family members of the employee/retired employee covered under Group Mediclaim. \_\_\_\_\_
3. Increased Sum Insured as per the option given vide Circular No. ZD/1003/ASP/2002 dated September 4, 2002 Rs. \_\_\_\_\_
4. Annual Premium per member Rs. \_\_\_\_\_
5. Total Premium recoverable/chargeable from the employee/retired employee Rs. \_\_\_\_\_

\_\_\_\_\_  
Signature of AAO/AO of OS Dept.  
where employee is working