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.e.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: _____

Name : _____

Address: _____

_____

_____

Date : _____

Place : _____

Signature of the
Employee/Retired Employee _____

Name of the
Employee/Retired Employee _____

Salary Roll No. : _____

Name of the
Office : _____

_____

_____

Date : _____

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