FAMILY MEDICLAIM FORM **{Form 7}**

(To be filled in BLOCK LETTERS only)

Company Name : _____

(As mentioned on the Offer Letter)

Emp. ID (Mandatory)	(*please refer Payslip*)
Name of the Employee	
Date of Joining	
Department	
Location	

DETAILS OF DEPENDENT FAMILY MEMBERS (MAX. 3 MEMBERS ONLY)
(FATHER, MOTHER, FATHERIN LAW, MOTHERIN LAW, SPOUSE, CHILDREN)

No.	Name	Date of Birth (dd/mm/yyyy) (Mandatory)	Age	Relationship	Existing ailment (if any)
1.					
2.					
3.					

Contact No. : _____

Employee Signature : _____