

MEDICAL INSURANCE SCHEME DECLARATION FORM

NAME : _____ SR No. _____ DESIGNATION : _____

Branch / Office :

To
The General Manager
Tamil Nadu Grama Bank
Head Office : Salem

Dear Sir/Madam,
Sub: MEDICAL INSURANCE SCHEME

Referring to the above, I hereunder furnish the details of self and dependant family members who shall be covered under the Medical Insurance Scheme.

S No.	Name of the person to be insured	Relationship	Date of Birth	Age	Gender	Occupation / Employment	Monthly Income	Marital status	Nominee Name	Nominee Relationship
		SELF								

I declare that the information furnished above is true, complete and correct in all respects and understand that in the event of any information being found false, incorrect or incomplete at any stage, Tamil Nadu Grama Bank Management reserves the right to initiate disciplinary proceedings against me and I further irrevocably agree to abide by the decision of the Bank's Management in this regard. I am fully aware of the eligibility criteria for including dependants under the definition of "Family" while availing Medical Insurance Scheme.

Yours faithfully,

Place :

Date :

Signature

(NAME: _____)

Note : Duly filled in above declaration form to be submitted to HO:HRM Dept., in both Hard and Soft copy.
Submit Soft copy through IP address of HO:HRM Department in "EXCEL" format kept in INTRANET.