HAMDARD INSTITUTE OF MEDICAL SCIENCES & RESEARCH AND ASSOCIATED HAH CENTENARY HOSPITAL

APPLICATION FORM FOR GROUP MEDICAL INSURANCE SCHEME

Financial Year: 2025-2026

Section 1: Employee Details (To be filled in block letters)

Employee Name	Mr /Ms
Date of Birth (DD/MM/YYYY)	
Contact No	
Email Address	
Employee ID	
Designation	
Department	
Date of Appointment	
Type of Appointment (select one)	Contractual ☐ Regular ☐
Date of Retirement	
Correspondence Address	

Section 2: Spouse Information (If Married)

Full Name	
Date of Birth (DD/MM/YYYY)	
Occupation	

Section 3: Children Information (If Applicable)

Please provide details for up to 2 children with the maximum age of 25 years (3 children only if 2nd child happened to be twins). A copy of each child's birth certificate is required for enrolment.

CHILD 1	
Full Name	

Date of Birth (DD/MM/YYYY)	
CHILD 2	
Full Name	
Date of Birth (DD/MM/YYYY)	

Section 4: Bank Details:

Bank Name	
Branch	
Account Number	
IFSC Code	

Section 4: Supporting Documentation

Please attach the following required documents:

- Copy of Appointment and Joining Letter
- Copy of Employee ID card
- Copy of Aadhar Card or PAN Card
- One cancelled bank cheque
- Copy of Spouse Aadhar Card or PAN Card
- If your spouse is currently employed, please attach a certificate from their employer confirming that they are not enrolled in any medical insurance plan
- Birth certificate for each child

Declaration

a. Certified that I am an employee of HIMSR/ HAHCH since _____ and have served for more than 1 year.
b. Certified that I am not receiving any medical benefits from Jamia Hamdard or my previous employer.
c. Certified that my spouse is not receiving and will not receive any medical benefits from his/her employer.
d. I hereby declare that the information provided in this application is true and accurate to the best of my knowledge. I understand that any false information or omission may result in denial of coverage or termination of benefits.

Name: _____

Date: _____ Signature: _____