UNITED INDIA INSURANCE COMPANY LIMITED

Regd. & Head Office : 24, Whites Road, Chennai – 600 014

ENROLLMENT FORM FOR GROUP MEDICLAIM POLICY [GMC 2025-2026]
(FLOATER BASIS WITH EFFECT FROM 01-04-2025)

Name of the Employee			
Mobile No.		**Employee No. & Office code**	
Email ID		**Designation & Department**	
Exit from service		**Opted Sum Insured**	**Rs.**
Residential Address			

Sum Insured to be covered in respect of the members listed below:

S. No	Name of the family member	Relationship	D.O.B.	Dependent	If Independent, income per month	Whether covered under any other medical scheme
1				Yes / No		
2				Yes / No		
3				Yes / No		
4				Yes / No		
5				Yes / No		
6				Yes / No		
7				Yes / No		
8				Yes / No		
9				Yes / No		
10				Yes / No		
11				Yes / No		
12				Yes / No		
13				Yes / No		
14				Yes / No		
15				Yes / No		
16						
17						
18						

I ,_____ hereby confirm that I have read, understood and accepted all the terms and conditions, exclusions and the scope of cover under the Staff Group Mediclaim Policy. I hereby nominate my _____[Relationship to Family Member] , namely, _____ [Full Name of Family Member], as the beneficiary of my Staff GMC policy. I, also hereby confirm that the above details furnished by me are true to the best of my knowledge and if found otherwise, the company shall have all the rights and authority to take suitable action (against me) as per applicable rules/law.

Place :
Date : **Signature of the Employee**

Note: Income for Dependent – Rs.9,000+DA p.m. as per circular No. HO:HR:CIR:28:2023 Dt.19.04.2023