**JGI REGISTRATION/ DECLARATION FORM - HEALTH INSURANCE COVERAGE-2023**

(All entries to be in capital letters, black ink)

Employee picture

Passport size

|  |  |
| --- | --- |
| **Documents required for registration** | **Tick appropriate** |
| i. | Attested copy of employee CNIC |  |
| ii. | Attested copy of spouse CNIC |  |
| iii. | NADRA marriage certificate |  |
| iv. | NADRA family registration certificate |  |
| v. | Attested copy of Son CNIC age less then 25 years  |  |
| vi. | Attested copy of daughter CNIC till unmarried |  |
| vii. | NADRA Children registration certificate less than 18 years |  |
| viii. | NADRA divorce certificate in case of divorce |  |
| ix. | Copy of BU appointment letter |  |
| x. | Photographs 1x1’’ ( in blue background) |  |

**EMPLOYEE DATA**

|  |  |  |
| --- | --- | --- |
| Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Designation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Department\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Employee Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Insurance ID#:\_\_\_\_\_\_\_\_\_\_(who already insured with insurance company) |
| Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_ | CNIC |  |  |  |  |  | - |  |  |  |  |  |  |  | - |  |
| Blood Group:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Mobile No: |  |  |  |  | - |  |  |  |  |  |  |  |
| IBAN # (24 Digits)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Present Residential Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**DEPENDENTS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **S.No**  | **Name**  | **Relation** | **D.O.B**  | **CNIC No** | **Photograph****(1 X 1)** |
| 1. | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |
| 2. | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |
| 3. | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |
| 4. | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |
| 5. | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |

It is certified that medical contribution toward medical health care is deducting as per policy in vogue

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employee’s Signature OIC Health Insurance / HoD Signature with Seal**