



# HIMALAYAN GENERAL INSURANCE CO. LTD.

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## EMPLOYEE ENROLLMENT FOR GROUP HOSPITAL INDEMNITY PLAN

EMPLOYER :		
ADDRESS :		
EMPLOYEE NAME :		
SEX	AGE LAST BIRTHDAY	DATE OF EMPLOYMENT
_____	_____	_____
CITIZENSHIP NO : _____		OCCUPATION : _____
<b>DEPENDENT INFORMATION</b>		
NAME	DATE OF BIRTH	SEX
Spouse :		
Child 1 :		
Child 2 :		
Child 3 :		
Child 4 :		
Child 5 :		

1. Have you or your dependents seen a doctor/specialist (except as a routine check-up), been under continuous medical treatment, hospitalised or suffering from recurring illness in the last 5 years ? YES [ ] NO [ ]
2. Are you or any of your dependents suffering from poor health or any physical impairment ? YES [ ] NO [ ]

If the answer is 'YES" to either question, please give details of the medical problem, duration, date of onset, and name of the doctor treating you on the reverse side of this form.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

I warrant that the above statements and particulars are true to the best of my knowledge and have been given faithfully based on all the facts known or ought to be known.