CONSENT FORM FOR GROUP MEDICAL HEALTH INSURANCE

EMPLOYEE FAMILY DETAILS

Name of the Employee: _____ Employee Code: _____

Department: _____ Date of Joining: _____

S. No.	Name	DOB	Age	Gender	Relationship with the Employee
1.					
2.					
3.					
4.					

- **Please tick (✔) the appropriate option:**

(I) I am **WILLING** to enrol for **GROUP MEDICAL HEALTH INSURANCE** provided by VNR VJIET.

(II) I am **NOT WILLING** to enrol for **GROUP MEDICAL HEALTH INSURANCE** provided by VNR VJIET.

Signature of the Employee _____ Date: _____

****** Fill in Capital Letters **** Details Should Match AADHAAR Details**

****** Filled in copy to be submitted to HR in person.**