MEDICLAIM ENROLMENT FORM

DGP NETWORK SOLUTIONS PVT. LTD.

Full Name (in CAPITAL letters):	_____
Present Address:	_____
Permanent Address:	_____
Designation:	_____
Date of Birth:	DOB: _____ / _____ / _____ In words: _____
Contact Numbers:	Mobile: _____ Emergency Contact Phone: _____

Add on (Please mention the details of the dependents you like to add with corporate Mediclaim group policy):
(Family definition – Employee + spouse + 2 dependent children + parents)

Name (In BLOCK Letters), as per ID proof	Gender	Date of Birth	Age	Relationship with Employee
1. _____	[ ] M [ ] F	__/__/____	___ Yrs	_____
2. _____	[ ] M [ ] F	__/__/____	___ Yrs	_____
3. _____	[ ] M [ ] F	__/__/____	___ Yrs	_____
4. _____	[ ] M [ ] F	__/__/____	___ Yrs	_____

SI / Age	0 - 35 Yrs	36 - 45 Yrs	46 - 55 Yrs	56 - 80 Yrs
INR 3,00,000/-	INR 3,217.21	INR 3,500.00	INR 7,000.00	INR 12,000.00

Note:
- The add on applicant should be a dependent on the primary applicant. There should be a blood relation between both primary and add on applicant.
- The Insurance cover for DGP Network member as well as dependents will cease at the time employee leaves the organization.
- Additions and deletions of the dependents can be done either at the time of joining or at the time of renewal. Only newly wed and new born child can be added in mid term.
- The amount will be adjusted once in a year with immediate month salary.
- Above premium is Excluded GST.

I would like to avail the mediclaim facility provided under the corporate mediclaim group of DGP Network Solutions Pvt. Ltd. For additional cover and add ons I shall be liable to pay all the necessary expenses and the same may be deducted from my salary.

_____

Signature of Employee
Date: _____ / _____ / 2026 | Place: _____