Life Insurance Corporation of India
Office Servicing Department,
Office: .....

OPTION FORM FOR INCREASED FAMILY FLOATER MEDICLAIM COVER

Name of Employee/Retired Employee.....

SR No. .....Department/Office.....

Basic Salary as on 01.04.2019.....(In case of serving employees)

Date of Retirement.....(In case of retired employees)

Category Applicable.....

Covered for compulsory Family Floater sum insured Rs.....

I, along with my family members, who have already been covered under our Group Mediclaim Policy as per rules, opt for the increased Family Floater sum insured (compulsory + additional) of Rs.....Lakh w.e.f. 01.04.2019 in terms of C.O. Circular No. CO/PER/ER-A/196/2018 dated 07/12/2018.

I, further certify that I have carefully gone through and understood the contents of this circular and shall abide by all the provisions of this circular and any subsequent modifications in terms and conditions in this regard.

I confirm that this option is irrevocable i.e. cannot be revoked by me. Particulars of my family members covered under Mediclaim Scheme are as under:

Signature of the Employee/Retired Employee: .....

Date..... Place.....

Signature of Witness..... Name of Witness.....

Address.....

Date..... Place.....

FOR OFFICE USE ONLY

1. Existing compulsory Family Floater Sum Insured of the employee/ retired employee Rs._____
2. No. of family members of the employee/retired employee covered under Group Mediclaim Scheme _____
3. Total Floater Sum Insured as per the option given vide Circular No. CO/PER/ER-A/196/2018 dated 07/12/2018 Rs. _____

Signature of AAO/AO of OS Dept.