**KRISHNA KANTA HANDIQUI STATE OPEN UNIVERSITY**

**Details of Family for Group Health Insurance**

Name of the Employee :

Employee ID No :

Designation :

Date of Birth :

Age :

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Sl. No. | Name of the Family Member | Relationship with the Employee | Age | Date of Birth | Remarks |
| 1 |  |  |  |  |  |
| 2 |  |  |  |  |  |
| 3 |  |  |  |  |  |
| 4 |  |  |  |  |  |
| 5 |  |  |  |  |  |
| 6 |  |  |  |  |  |
| 7 |  |  |  |  |  |
| 8 |  |  |  |  |  |

N.B.: “*Family*” for this purpose means a family as defined in Rule 1(d) of the Medical Assistance Rule of KKHSOU: (Dependent may be spouse, dependent son/unmarried daughter, Parents).

I, ……………………………………….. declare that Rs 600/- will be deducted as Monthly Premium for Employee Group Medical Health Insurance from my monthly salary.

Date: Signature

Please submit on or before……………..