THE UNIVERSAL INSURANCE COMPANY LIMITED

EMPLOYEE DATA FORM

(To be filled in by Employee)

Category:

Organization Name _____

Organization Address _____

Employee Name _____

S/o, D/o, W/o _____

Date of Birth _____

Male/Female _____

Designation _____

National ID card No _____

Please attach Photograph & Copy of N-I-C

S No.	NAME OF DEPENDENTS	DATE oF BIRTH	RELATION	NIC No.
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

Would the employee or the dependent require the Maternity cover? **YES/NO.**

If Yes, Pregnant since _____ months

	Name of the sufferer		Name of the sufferer
Previous By-pass (Date)		Osteo Arthiritis	
Myocardial Infarction (heart attack)/ Angioplasty		Rheumatoid Artheritis	
Cerebra-vascular accident (Stroke)		Uicerative Colitis	
Hypertension (Blood Pressure)		Rheumatoid Artheritis	
Angina		TB	
Cardio Myopathy (C.M.P)		Chronic Obstructive Pulmonary Disease	
Kidney Disease(Chronic Renal Failure/ Renal Stones)		Bronchial Asthma	
Cancer		Epilepsy	
AIDS		Spondolysis	
Chronic liver Diseases		Catract	
Hepatitis B		Glaucom	
Hepatitis C		Diabetic Retino Pathy	
Major Burns		Psychiatric Disorder	
Diabetes - Mellitus		Any Congenital Disease (by birth)	
Hypothyroidism / Hyperthyroidism		Any Surgery	
S.L.E(Systemic Lupus Erythematosus			

It is requested that a true state of health / disease should be disclosed in the form, not withholding any fact to the best of his / her knowledge. This will help us fast processing of claim.

DECLARATION

I _____ S/O, D/O, W/O _____ DO HEREBY, SOLEMENLY AFFIRM THAT ALL THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

_____ Name and Signature of Employee

_____ Signature and Stamp of Employer