Annexure to Instruction Circular No11007/ADMN(HR)/2010-2011/04 dated 31/05/2010.

ANNEXURE - "A"

MEMBERSHIP FORM FOR NEW MEMBERS

PF No.	

Through : **Branch/Office of Posting**

ALLAHABAD BANK SCHEME FOR GROUP MEDICLAIM INSURANCE POLICY WITH GROUP PERSONAL ACCIDENT INSURANCE COVERAGE FOR OFFICERS AND EMPLOYEES ALONGWITH THEIR WHOLLY DEPENDENT FAMILY MEMBERS

I hereby declare that I have read, understood and accepted the terms and conditions of the aforesaid scheme circularised vide Instruction Circular No. …….. dated ……

That the following members of my family may please be covered under the aforesaid scheme along with me whose names are entered in the Bank's record as my wholly dependent family members (maximum three persons).

Sl. No.	Full Name of Dependent	Date of Birth	Relation-ship	Occu-pation & Monthly Income	Blood Group	Sex	Full Signature	Name of Nominee to receive claim amount under the scheme in the event of death of insured person
		(DD/MM/YYYY)						
		(DD/MM/YYYY)						
		(DD/MM/YYYY)						

Further, I also declare that this option/declaration is final, irrevocable and wholly binding on me. In the event of ineligibility of the dependent members due to death/ exceeding the monthly income of insured persons/other reason, I shall intimate the same to the Bank alongwith the name of the new family member(s) to be inducted, if any, immediately. I also understand and accept that the Bank is in no way responsible for payment of any amount under the scheme except what is admissible/payable by the Insurance Company.

I hereby affix **two stamp size colour photographs** each for self and for each of the dependent family members stated above for Medical Card per individual.

Yours faithfully,

Date :……..
Place:……..

(Full Signature)

Officer / Employee Data

(a) Full Name : ....

(b) Designation : ....

(c) Branch/Office : ....

(d) Zonal Office : ……

(e) Residential Address : ....

....

(f) P. F. No. : .....

(g) Date of Birth : .....

(h) Sex : .....

(i) Date of Appointment : .....

Signature of Shri/Smt. ……

A T T E S T E D

Signature of the Branch Manager/Chief Manager/Departmental Head of ZO/HO/Office

Full Name : ……

Date : ……

SEAL

NOTE :

i) Additions/alterations in the text of the application form (Annexure-'A') will render the option invalid.

ii) Incomplete application received will not be considered ;

iii) Benefit is available subject to acceptance of the membership by the Insurance Company from the date stipulated by them ;

iv) Please indicate the name(s) of new born baby invariably otherwise their membership/claim will not be entertained.

v) Please quote the P.F. No. in all related correspondences.

PLEASE AFFIX **TWO STAMP SIZE COLOUR PHOTOGRAPHS**
EACH FOR SELF AND FOR EACH OF THE DEPENDENT FAMILY
MEMBERS FOR **MEDICAL CARD** PER INDIVIDUAL
(Please write the name of the respective person behind each photograph)

Full Name of the Officer/ Employee :	Full Name of the 1st dependent family Member :	Full Name of the 2nd dependent family Member:	Full Name of the 3rd dependent family Member:
Date of Birth :	Date of Birth :	Date of Birth :	Date of Birth :
Blood Group :	Blood Group :	Blood Group :	Blood Group :
Branch Office :	Relationship with Officer/ Employee :	Relationship with Officer/ Employee :	Relationship with Officer/ Employee :
Residential Address :			
Telephone No: (Resi) :			
(Office) :			
PF No.	PF No of the Main Member.	PF No of the Main Member.	PF No of the Main Member.