



# HIMALAYAN GENERAL INSURANCE CO. LTD.

Head Office: Babarmahal, G.P.O. Box 148, Kathmandu, Nepal.

Tel: 4231788, Fax: 4241517, E-mail: ktm@hgi.com.np

Branches: Birgunj - Biratnagar - Pokhara - Durbarmarg - Butwal - Lalitpur  
525366 528524 462100 4231581 622315 5001810

## GROUP HOSPITAL INCOME POLICY PROPOSAL

COMPANY NAME : \_\_\_\_\_

ADDRESS : \_\_\_\_\_

BUSINESS : \_\_\_\_\_

PERIOD OF INSURANCE : FROM \_\_\_\_\_ TO \_\_\_\_\_

1. PLEASE STATE CATEGORY OF EMPLOYEE TO BE COVERED BY EACH PLAN

PLAN	CATEGORY OF EMPLOYEE
A. Rs. 600 PER DAY	_____
B. Rs. 1,200 PER DAY	_____
C. Rs. 1,800 PER DAY	_____
D. Rs. 3,000 PER DAY	_____

2. DO YOU REQUIRE OVERSEAS EXTENTION? \_\_\_\_\_

3. DO YOU REQUIRE RIOT & STRIKE EXTENTION? \_\_\_\_\_

4. WHAT IS YOUR TOTAL WORKFORCE? \_\_\_\_\_

5. DO YOU REQUIRED CONTRIBUTIONS FROM EMPLOYEES FOR HEALTH INSURANCE?

A. EMPLOYEE ? \_\_\_\_\_

B. EMPLOYEE & SPOUSE ? \_\_\_\_\_

C. EMPLOYEE & FAMILY ? \_\_\_\_\_

DATED: \_\_\_\_\_

SIGNED: \_\_\_\_\_



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## EMPLOYEE ENROLLMENT FOR GROUP HOSPITAL INDEMNITY PLAN

EMPLOYER :		
ADDRESS :		
EMPLOYEE NAME :		
SEX	AGE LAST BIRTHDAY	DATE OF EMPLOYMENT
_____	_____	_____
CITIZENSHIP NO : _____		OCCUPATION : _____
<b>DEPENDENT INFORMATION</b>		
NAME	DATE OF BIRTH	SEX
Spouse :		
Child 1 :		
Child 2 :		
Child 3 :		
Child 4 :		
Child 5 :		

1. Have you or your dependents seen a doctor/specialist (except as a routine check-up), been under continuous medical treatment, hospitalised or suffering from recurring illness in the last 5 years ? YES [ ] NO [ ]
2. Are you or any of your dependents suffering from poor health or any physical impairment ? YES [ ] NO [ ]

If the answer is 'YES' to either question, please give details of the medical problem, duration, date of onset, and name of the doctor treating you on the reverse side of this form.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

I warrant that the above statements and particulars are true to the best of my knowledge and have been given faithfully based on all the facts known or ought to be known.