

Indian Officers Working on INSA / MUI Agreement

The Merchant Navy Officer's Welfare Fund

"UDYOG BHAVAN", 4th Floor, 29, Walchand Hirachand Marg, Ballard Estate,
Mumbai – 400 038

**MEDICAL WELFARE SCHEME
HEALTH STATEMENT**

(To be filled in by the Officer in his own handwriting)

To,

The Merchant Navy Officer's Welfare Fund,
Mumbai.

I give below particulars of the members of my family and the state of their health. The Statements made and answers given herein are correct and wholly true and it is understood and agreed that these are the basis on which reimbursements may be granted to me by Medical Scheme. I further agree that if it is found that the statement and answers are in any respect incorrect or untrue, the Medical Scheme shall be under no obligation to pay any claim made by me or if any payment has been made, I shall be liable to reimburse the Merchant Navy Officers' Welfare fund the amount paid to me on any claim.

1. Officer's full name : _____

2. Designation : _____ 3. Present Company employed in : _____

_____ Whether on Contract or MUI Terms _____

4. Date of employment : _____

5. Particulars of Service during the last 4 years with dates : _____

6. Residential Address _____

Tel. No. with STD Code : _____ Mobile No. : _____

7. Name of your family Doctor, his qualification and address : _____

8. Are you, and Members of your family given below, in good health ? If not, mention specific

ailments: _____

9. Are you, your Wife and/or children covered with any Insurance Company under any Medical Scheme?

If so name the Company/ies, type and amount of coverage _____

10. Is your wife gainfully employed ? If so give particulars of her employment: _____

11. PARTICULARS OF FAMILY MEMBERS :

Name in Full (Block Letters)	Relationship	Date of Birth	Height	Weight
1. Mr. _____	Self			
2. Mrs. _____	Wife			
3. _____	Children			
4. _____				
5. _____				
6. _____				
7. _____				

I hereby certify and declare that the above statements are true to the best of my knowledge and belief. I have received a copy of the Medical Brochure and Claim Forms.

Place :

(Signature of Officer)

Date :

Designation :

Company