



THE ORIENTAL INSURANCE COMPANY LIMITED

First Floor, 7 Red Cross place, Kolkata, West Bengal 700001

Annexure –A2

CONSENT FORM FOR EXISTING BENEFICIARIES

- (1) WBPDC GROUP TAILORMADE LOSS RECOVERY MEDICLAIM SCHEME (On Roll employees) &
- (2) WBPDC GROUP TAILORMADE CASHLESS MEDICLAIM SCHEME (Retired employees)

I, Shri / Smt (BLOCK LETTER) / Emp. No. / (PPO No. / Ex-Emp No.)
 resident of / posted at
 (SITE / CORRESPONDENCE ADDRESS) having read the policy terms & conditions notified vide Circular No.:
 COHRA05010006/3432 dated 03.07.2017 hereby consent to enroll for the

- (1) WBPDC Group Tailor made Loss Recovery Mediclaim Scheme (**ON ROLL EMPLOYEE**)
- (2) WBPDC Group Tailor made Cashless Mediclaim Scheme (**RETIRED EMPLOYEE**)
- (strike out the not applicable)

ENROLLMENT DETAILS (as per family definition mentioned in Circular No.: COHRA05010006/3432 dated 03.07.2017)

Name of Employee / Retired Employee & Dependant Member	Relationship with Employee	DOB (DD/MM/YYYY)	Age	Sex	Sum Insured (Floater)

- 01. I do hereby authorize WBPDC to deduct the premium amount calculated by the insurance company on basis of particulars submitted by me from the salary / pension payable to me commencing from the month following acceptance of my proposal by the insurance company. Understood that for retired employees not covered by GPF cash deposit of premium amount is to be made at either Cash Section of KTPS, BTPS, BkTPP, STPS, SgTPP, Corporate Office, WBPDC.
- 02. I hereby confirm that the claim settled by the insurance company shall be deemed final and do hereby undertake that I shall not hold WBPDC liable for reimbursement of short settlement, if any, made by the insurance company as per the rules and regulations of the scheme.
- 03. I further declare that I shall abide by the rules and regulations framed under the scheme covered by the Memorandum of Understanding entered between The Oriental Insurance Company Limited and The West Bengal Power Development Corporation Limited.
- 04. I do confirm that the information furnished by me above are true to the best of my knowledge and belief.

Signature of Employee :
 Name of Employee (Block Letters) :
 Contact No. :
 Email ID :

Office Use:
 Money Receipt No. & Date : Receipt No.: Date: Sum Insured:
 (For CPF member paying premium in cash) Premium: GST @ 18%: Total Premium: