

# Application Form - Agrahara Health Insurance

## Uva Wellassa University

### 1. Personal Details:

- 1.1. Full Name: .....
- 1.2. Name with Initials: .....
- 1.3. Birth Day: .....
- 1.4. Designation: .....
- 1.5. NIC No: .....
- 1.6. Address: .....  
.....
- 1.7. City: .....
- 1.8. Mobile No: .....
- 1.9. UPF No: .....

### 2. Account Details:

- 2.1. Bank name & Code: .....
- 2.2. Branch name & Code: .....
- 2.3. Account No: .....

### 3. Dependent Information:

- Note: For each dependent (up to 05), please provide the following Details
- Unmarried-Father & Mother (below 70 years)
- Married-Wife/Husband/Children (below 21)

No	Name with Initials of Dependent	Date of birth	NIC number	Relationship of Dependent
3.1				
3.2				
3.3				
3.4				
3.5				
3.6				

I hereby agree to enroll in the Agrahara Health Insurance Scheme and confirm that all the details furnished in this application are true and correct to the best of my knowledge. I understand the rules, conditions, and benefits of the scheme and undertake to abide by them. I also agree to pay the relevant contributions (Rs.1800.00) as a deduction from my salary.

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Signature

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Date