**INDIAN INSTITUTE OF SCIENCE, BANGALORE**

**OPTION FORM**

**For Additional Health Insurance Coverage**

**(over and above the basic coverage of Rs. 1,50,000/-)**

**for the Period 01.08.2019 to 31.07.2020**

(Name of the Insurance Company - M/s Star Health and Allied Insurance Company Ltd.)

|  |  |  |  |
| --- | --- | --- | --- |
| 1 | Category  (Please tick any one) | Employee |  |
| Pensioner |  |
| 2 | Employee’s / Pensioner’s  ID No. |  | |
| 3 | Name |  | |
| 4 | Date of Birth (DD-MM-YYYY) |  | |
| 5 | Age as on 01.08.2019 |  | |
| 6 | Designation |  | |
| 7 | Department |  | |
| 8 | Additional Coverage required for | In Figures – Rs.  In words – Rs. | |
| 9 | Annual Premium Amount | In Figures – Rs.  In words – Rs. | |
| 10. | Number of Installments  (Please tick any one) | ONE |  |
| TWO |  |
| THREE |  |

I hereby authorize the Financial Controller, IISc, Bangalore to deduct the premium mentioned as per my option filled-in above at Sl. No. 9 from my Salary / Pension.

**Date: Signature**

**Name:**