SICL MEMBERSHIP FORM

(Revised - 2017)

PERSONAL

Purpose (Strike out which is not applicable)			Registration with SICL / Yearly Membership / Addition / Deletion of Family Members		
Pay Grade (Spl-I, M-1, S-1, etc)			Proposed SICL Plan (See Note No 1)		
Organization Name and Address			Contact Person		
			Tele No		
Individual Name			S/O, D/O, W/O		
Designation			Place of Posting		
Date of Joining			CNIC No		
Date of Birth & Age			Gender		Cell /Tel #	
Mailing Address					

DEPENDENTS

S #	Name	Relation	Age	DOB	CNIC No
1					
2					
3					
4					
5					
6					
7					

If Pregnant then kindly state since _____ Months

Which of the following (If any) is the employee or the dependent suffering from ?

Diseases	Name of Sufferer
Myocardial Infarction (Hear Attack)	
Previous By-Pass (Date)	
Cancer	
Cerebra-vascular accident (Stroke)	
Kidney Disease	
AIDS	
Hepatitis 'B'	
Hepatitis 'C'	
Major Burns	
Diabetes	
Hypertension (Blood Pressure)	
Angina	
TB	
Epilepsy	
Psychiatric Disorder	
Any Congenital Disease (By birth)	

It is requested that a true state of health / disease should be disclosed in the form, not withholding any fact to the best of his / her knowledge. This will help us in your claim reimbursement & processing.

DECLARATION

I _____ S/O, D/O, W/O _____do hereby, solemnly affirm that all the information provided by me is true and correct to the best of my knowledge.

_____ _____

Name and signature of Employee Name and Signature of Employer

NOTE:

1. Plans: A = (M-4 & Above), B = (S-2 to M-5), C = (S-3 & Below).
2. The following documents should accompany the filled out form (only in case of registration with SICL).
   (a) Photocopy of CNIC of the employee & dependents.
   (b) Two photographs of the employees and the covered dependents.
   (c) Attach "B" Form for dependents under 18 years of age.
3. Another form can be used in case more dependents.