HEALTH CENTRE

INDIAN INSTITUTE OF SCIENCE

OPTION FORM

(FOR ADDITIONAL INSURANCE COVER)

|  |  |  |
| --- | --- | --- |
|  | Employee/Pensioner ID No. |  |
|  | Name  |  |
|  | Date of Birth |  |
|  | Age |  |
|  | Designation |  |
|  | Department |  |
|  | Additional Coverage required for |  |
|  | Premium Amount |  |

I hereby authorize the Financial Controller, IISc., to deduct the premium

mention at Sl.No. 8 above from my salary/pension.

 SIGNATURE