OPTION FORM FOR ENHANCE / REDUCE THE SUM INSURED IN THE UPCOMING / NEW GROUP MEDICAL INSURANCE POLICY w.e.f. 01.09.2025 FOR RETIRED EMPLOYEES OF WBSETCL

(To be submitted by 23-05-2025)

1	Name of the Optee (in Block letters)		Date of Birth (DD/MM/YYYY)	
2	Name of the Spouse (in Block letters)		Date of Birth (DD/MM/YYYY)	
3	Address			
		District:	PIN Code:	
4	Contact No:	Mob: (i)	(ii)	
5	Email ID:			
6	PPO No: (for Pensioner / Family Pensioner only)		Date of Retirement	
7	PF No: (for CPF Holders only)		Date of Retirement	
8	Please provide the following details (Kindly tick on the appropriate option):-			
8 (a)	Whether the optee would like to change his/her existing scheme (i.e. Part A (Rs. 2, 00,000/-)/ Part B (Rs. 3, 50,000/-)/ Part C (Rs. 5, 00,000/-)) in the upcoming/new policy w.e.f. 01-09-2025?	Yes	No	
8 (b)	If yes, then mention the Scheme [Part A (Rs. 2, 00,000/-)/ Part B (Rs. 3, 50,000/-) /Part C (Rs. 5, 00,000/-)] for inclusion in the upcoming/new policy w.e.f. 01-09-2025.	Part A	Part B	Part C
		(TICK on the right box only)		

NB: For CPF account holders, Online Payment (UPI/QR Code/Bank transfer) will have to be done, after the final notification as per the option exercised for acceptance of option form.

* I hereby state that the particulars provided by me are correct and true to the best of my belief.

Date:	
Place:	(Signature)