



# THE UNIVERSAL INSURANCE COMPANY LIMITED

## EMPLOYEE DATA FORM

(To be filled in by Employee)

Category:

Organization Name \_\_\_\_\_  
 Organization Address \_\_\_\_\_  
 Employee Name \_\_\_\_\_  
 S/o, D/o, W/o \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Male/Female \_\_\_\_\_  
 Designation \_\_\_\_\_  
 National ID card No \_\_\_\_\_

**Please attach  
 Photograph  
 &  
 Copy of N-I-C**

S No.	NAME OF DEPENDENTS	DATE OF BIRTH	RELATION	NIC No.
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

Would the employee or the dependent require the Maternity cover? **YES/NO.**

If Yes, Pregnant since \_\_\_\_\_ months

	Name of the sufferer	Name of the sufferer
Previous By-pass (Date)	Osteo Arthritis	
Myocardial Infarction (heart attack)/ Angioplasty	Rheumatoid Arthritis	
Cerebra-vascular accident (Stroke)	Uicerative Colitis	
Hypertension (Blood Pressure)	Rheumatoid Arthritis	
Angina	TB	
Cardio Myopathy (C.M.P)	Chronic Obstructive Pulmonary Disease	
Kidney Disease(Chronic Renal Failure/ Renal Stones)	Bronchial Asthma	
Cancer	Epilepsy	
AIDS	Spondylolysis	
Chronic liver Diseases	Catract	
Hepatitis B	Glaucom	
Hepatitis C	Diabetic Retino Pathy	
Major Burns	Psychiatric Disorder	
Diabetes - Mellitus	Any Congenital Disease (by birth)	
Hypothyroidism / Hyperthyroidism	Any Surgery	
S.L.E(Systemic Lupus Erythematosus)		

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 fast processing of claim.

### DECLARATION

I \_\_\_\_\_ S/O, D/O, W/O \_\_\_\_\_ DO HEREBY, SOLEMENLY AFFIRM THAT ALL THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

\_\_\_\_\_  
Name and Signature of Employee

\_\_\_\_\_  
Signature and Stamp of Employer