STATE LIFE

INSURANCE CORPORATION OF PAKISTAN

FORM NO: [H101]

CORPORATE CLIENT DETAILS

CORPORATE HEALTH INSURANCE CLIENT DATA

Employer Name:	
Employer Address (H.O):	
City:	Postal Code:
Province:	Employer Type: ☐ Public ☐ Private ☐ Semi-Private
Total Number of Offices in Pakistan:	
Total Number of Employees:	Total Number of Dependents:
Total Number of Lives:	Active Tax Payer: ☐ Yes ☐ No NTN: _____

Dependents to be Covered: ☐ Spouse ☐ Children ☐ Parents ☐ Other _____

Focal Person:	Cell:	Landline:	Email

Focal Person for State life: _____ Region: _____ Contact No: _____ Email: _____

Benefit Details:

Benefits	Status	Details	Remarks
Scope:	☐ Per Member ☐ Per Family		
Inpatient	☐ Covered ☐ Not Covered	Age Limit: S ___ SP ___ C ___ P ___	
Maternity:	☐ Covered ☐ Not Covered	Age Limit: S ___ SP ___	
OPD:	☐ Covered ☐ Not Covered	☐ Pool ☐ Premium	
Vaccination:	☐ Covered ☐ Not Covered	☐ From OPD ☐ From IPD	
ER Treatment:	☐ Covered ☐ Not Covered	Mention Sublimit here	Example Cat A: 35K Cat B: 25K
Day Care Surgeries:	☐ Covered ☐ Not Covered	Mention Sublimit here	Example Cat A: 35K Cat B: 25K
Cataract Lens Limit:	☐ Standard Upto Rs. 40,000/-	Mention Sublimit here	Example Cat A: 35K Cat B: 25K
Pre/Post Natal:	☐ Covered ☐ Not Covered	Pre-Days: ___ Post Days: ____	
Pre/Post Hospitalization:	☐ Covered ☐ Not Covered	Pre-Days: ___ Post Days: ____	
Organ Transplant:	☐ Covered ☐ Not Covered	Mention Sublimit here	Example Cat A: 35K Cat B: 25K
Laboratory Investigations:	☐ Covered ☐ Not Covered	Mention Sublimit here	Example Cat A: 35K Cat B: 25K
Pre-Existing Conditions:	☐ Covered ☐ Not Covered	Covered Upto _____ %	
Congenital Conditions:	☐ Covered ☐ Not Covered	Mention Sublimit here	Example Cat A: 35K Cat B: 25K
Covid-19 Coverage:	☐ Covered ☐ Not Covered	Mention Sublimit here	Example Cat A: 35K Cat B: 25K
Dental Preventive (Cleaning etc.)	☐ Covered ☐ Not Covered	☐ From OPD ☐ From IPD ☐ _____	
Dental Restorative (RCT, filling etc.)	☐ Covered ☐ Not Covered	☐ From OPD ☐ From IPD ☐ _____	
Dental Cosmetic (Scaling etc.)	☐ Covered ☐ Not Covered	☐ From OPD ☐ From IPD ☐ _____	
Major Dental (Implants, Bridge etc.)	☐ Covered ☐ Not Covered	☐ From OPD ☐ From IPD ☐ _____	
Circumcision:	☐ Covered ☐ Not Covered	☐ From OPD ☐ From IPD ☐ _____	
Cosmetic:	☐ Covered ☐ Not Covered	Mention Sublimit here	Example Cat A: 35K Cat B: 25K
Local Ambulance Charges:	☐ Covered ☐ Not Covered	☐ From OPD ☐ From IPD ☐ _____	
Home Nursing Care	☐ Covered ☐ Not Covered	☐ From OPD ☐ From IPD ☐ _____	
Food Supplements	☐ Covered ☐ Not Covered		Entitlement
Room Amenities	☐ Covered ☐ Not Covered	☐ From IPD ☐ _____	
Mental Illness	☐ Covered ☐ Not Covered	☐ From OPD ☐ From IPD ☐ _____	
Homeopathic care	☐ Covered ☐ Not Covered	☐ From OPD ☐ _____	
Funeral Expense	☐ Covered ☐ Not Covered	☐ From IPD ☐ _____	
Interferon Therapy	☐ Covered ☐ Not Covered	☐ From OPD ☐ _____	
Fair & Equitable Policy	☐ Similar Panel ☐ Restriction	☐ Restriction % _____	

Category	A	B	C	D	E	F	G	H
Inpatient Limit								
Accidental Enhancement								
Room Limit								
Room Entitlement								
OPD Limits								
Maternity-Complicated								
Maternity-Normal								
Gel or Any other Pool								