



**To Avail Healthfriend Facilities FAMILY INFORMATION FORM**

Please select the appropriate option and fill the details accordingly. Please  If Yes or  No

Any addition / deletion in the family information form can be done by separate application as and when applicable along with valid proof / support documents.

\* Refer our healthfriend guide for centers and rules and regulation

<input type="checkbox"/>	<b>SPOUSE (Wife/Husband)</b>												
		LAST NAME	FIRST NAME	MIDDLE NAME									
Date of Birth	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	Age: <input type="text" value=""/> <input type="text" value=""/>	Sex: <input type="checkbox"/> M / <input type="checkbox"/> F										
<input type="checkbox"/>	<b>CHILD 1 (Unmarried)</b>												
		LAST NAME	FIRST NAME	MIDDLE NAME									
Date of Birth	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	Age: <input type="text" value=""/> <input type="text" value=""/>	Sex: <input type="checkbox"/> M / <input type="checkbox"/> F										
<input type="checkbox"/>	<b>CHILD 2 (Unmarried)</b>												
		LAST NAME	FIRST NAME	MIDDLE NAME									
Date of Birth	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	Age: <input type="text" value=""/> <input type="text" value=""/>	Sex: <input type="checkbox"/> M / <input type="checkbox"/> F										

<input type="checkbox"/>	<b>SELF FATHER</b>												
		LAST NAME	FIRST NAME	MIDDLE NAME									
Date of Birth	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	Age: <input type="text" value=""/> <input type="text" value=""/>	Sex: <input type="checkbox"/> M / <input type="checkbox"/> F										
<input type="checkbox"/>	<b>SELF MOTHER</b>												
		LAST NAME	FIRST NAME	MIDDLE NAME									
Date of Birth	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	Age: <input type="text" value=""/> <input type="text" value=""/>	Sex: <input type="checkbox"/> M / <input type="checkbox"/> F										

<input type="checkbox"/>	<b>SPOUSE FATHER</b>												
		LAST NAME	FIRST NAME	MIDDLE NAME									
Date of Birth	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	Age: <input type="text" value=""/> <input type="text" value=""/>	Sex: <input type="checkbox"/> M / <input type="checkbox"/> F										
<input type="checkbox"/>	<b>SPOUSE MOTHER</b>												
		LAST NAME	FIRST NAME	MIDDLE NAME									
Date of Birth	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	Age: <input type="text" value=""/> <input type="text" value=""/>	Sex: <input type="checkbox"/> M / <input type="checkbox"/> F										

**DECLARATION**

I \_\_\_\_\_ son/daughter/wife of \_\_\_\_\_ hereby declare that every thing written in this form and in the Family Information Form (FIF) is completely true and no material has been concealed from the Company. I understand that if any information mentioned in the form or the FIF is discovered to be false or if any material information is found to be withheld by me, the Company shall be entitled to terminate the contract with me and withdraw the Facility with immediate effect. I have read and understood all the terms and conditions and will be bound by the same

Signature of CD/Customer ✓ \_\_\_\_\_

Customer ID