

Member/Dependent Deletion Form

Deletion Request

Request For		Effective Date
<input type="checkbox"/> Member Deletion	<input type="checkbox"/> Dependent Deletion	DD/MM/YYYY
Reason For Member Deletion		Reason For Dependent Deletion
<input type="checkbox"/> Left Employment		<input type="checkbox"/> Divorce
<input type="checkbox"/> Lay Off		<input type="checkbox"/> Death
<input type="checkbox"/> Others (Please Explain)		<input type="checkbox"/> Others (Please Explain)

Deleted Member/Dependent Information

No	Full Name	Membership No	Number Of Dependents
1			
2			
3			
4			
5			

Section to be filled by Organization

Employee Signature:	
Authorizer Signature:	
Date:	DD/MM/YYYY
Stamp:	

Section to be filled by Amanah Insurance

FINANCE DEPARTMENT		MEDICAL UNDERWRITING DEPARTMENT	
confirmed		Deletion confirmed	
Signature		Signature	
Date:	DD/MM/YYYY	Date:	DD/MM/YYYY