Dependent Addition Form

Principle Member Information

Full Name	Membership Number

Phone Number	Email Address

Dependent Addition Reason

Reason	Effective Date
☐ Marriage ☐ Birth	DD/MM/YYY

Dependent Information

No	Full Name	Date Of Birth	Gender	Relationship
1		DD/MM/YYY	☐ Male ☐ Female	
2		DD/MM/YYY	☐ Male ☐ Female	
3		DD/MM/YYY	☐ Male ☐ Female	
4		DD/MM/YYY	☐ Male ☐ Female	
5		DD/MM/YYY	☐ Male ☐ Female	
6		DD/MM/YYY	☐ Male ☐ Female	
7		DD/MM/YYY	☐ Male ☐ Female	

Section to be filled by Organization

Authorizer Name:	
Authorizer	
Signature: Date:	DD/MM/YYY
Stamp:	

Section to be filled by Amanah Insurance

FINANCE DEPARTMENT		MEDICAL UNDERWRITING DEPARTMENT	
Printing Confirmed		Printing Confirmed	
Signature		Signature	
Date:	DD/MM/YYY	Date:	DD/MM/YYY