Medical Application Form

Amanah INSURANCE
TRUSTED SERVICES

Person Particular of the Applicant

Name of The Insured Company		Title Proposal Commencement Date
	[ ] MR. [ ] MRS. [ ] MISS..	Day Month Year _____/_____/_____

First Name	Middle Name	Date of Birth	ID/Passport

Gender	Marital Status	Date of Birth	Mobile Number	Alternative Mobile Number
[ ] Male [ ] Female	[ ] Single [ ] Married	Day Month Year _____/_____/_____		

Blood Group	Height (Cm)	Weight (Cm)	Email Address

Specific Occupation/Designation	Date of Employment	Staff Payroll No.
	Day Month Year _____/_____/_____	

Particulars of Dependents to be Included on Cover

No.	Full Name or Dependent (Surname First)	Dependent Type (Spouse/Child)	Gender (M/F)	Date of Birth	Blood Group	I.D No.