AMANAH INSURANCE

GROUP MEDICARE AMANAH
DEPENDANT ADDITION FORM

APPLICATION INSTRUCTIONS:

1. This Form use only Dependents **ADDITION** of the Existing Member with Amanah Insurance
2. To be completed by Employee (On behalf of his Dependents).
5. Application Form must be **signed** and **stamped** by your **HR/Admin Manager.**

1. PRINCIPAL MEMBER INFORMATION

Full Name of Principal Member	
Membership No **(Mandatory)**	
Policy No	

2. CHANGE INFORMATION

Reason for ADDING Dependents (Please Select)										
	Marriage									
	Birth									
	Others (Pls. Explain)	**With Effect From**	D	D	M	M	Y	Y	Y	

3. DETAILS OF DEPENDANT(S)

[Please note children will be eligible for cover from the age of 61 Days up to 21 years (Unmarried Only). Children above 21 years but below 25 years may be accepted on proof of fulltime schooling.]

No	Full Name	Date of Birth								Gender		Relation
1		D	D	M	M	Y	Y	Y	Y	M	F	
2		D	D	M	M	Y	Y	Y	Y	M	F	
3		D	D	M	M	Y	Y	Y	Y	M	F	
4		D	D	M	M	Y	Y	Y	Y	M	F	
5		D	D	M	M	Y	Y	Y	Y	M	F	
6		D	D	M	M	Y	Y	Y	Y	M	F	
7		D	D	M	M	Y	Y	Y	Y	M	F	
8		D	D	M	M	Y	Y	Y	Y	M	F	

_____/_____/_____ _____

Date **Signature of Principal Member**

THIS SECTION FILLED UP BY THE EMPLOYER/ORGANIZATION

Stamp of Employer (Mandatory)

Signature of Authorized Person of Employer

_____

Date:

___/____/_____

Full Name:

_____