ALGHANIM INDUSTRIES
GROUP LIFE & MEDICAL PLAN

APPLICATION FORM

PF NO : _____ NAME : _____ SEX : _____
FIRST MIDDLE LAST

COUNTRY OF CITIZENSHIP : _____ DATE OF BIRTH : _____

MARITAL STATUS : SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐

DATE EMPLOYED : _____ JOB TITLE : _____ GROUP : _____

NOMINATED BENEFICIARY(IES) : _____

_____

WERE YOU ACTIVELY AT WORK DURING THE LAST 3 MONTHS ? _____

PLEASE FILL THE ATTACHED HEALTH DECLARATION FORM FOR YOURSELF AND ALL YOUR DEPENDENTS, IF INSURED.

I HEREBY DECLARE THAT, TO THE BEST OF MY KNOWLEDGE, ALL ABOVE STATEMENTS ARE TRUE AND COMPLETE.

DATE : _____ SIGNATURE _____

- ANY CHANGE IN BENEFICIARY(IES) OR NUMBER OF DEPENDENTS SHOULD BE NOTIFIED IN WRITING TO ENSURE APPROPRIATE COVER IS MAINTAINED.
- COMPLETE COVERAGE IS PROVIDED FREE BY THE COMPANY TO ALL ITS ELIGIBLE EMPLOYEES. MEDICAL INSURANCE BENEFITS ARE EXTENDED TO COVER DEPENDENTS AGAINST THE EMPLOYEE'S PAYMENT OF THE THEN APPLICABLE MONTHLY CONTRIBUTION. HOWEVER, ANY EMPLOYEE CAN OPT NOT TO INCLUDE HIS DEPENDENTS BY COMPLETING NEXT SECTION.

*COMPLETE THIS SECTION ONLY IF YOU WISH TO **EXCLUDE** YOUR DEPENDENTS FROM MEDICAL COVER*

I HEREBY DECLINE TO ENROLL MY DEPENDENTS UNDER THE MEDICAL PLAN OF THE COMPANY'S GROUP POLICY, AND UNDERSTAND THAT THIS IS A ONE TIME IRREVOCABLE DECISION, I.E. THEY CAN NEVER BE ENROLLED IN THE FUTURE.

DATE : _____ SIGNATURE _____

DOCTOR'S EVALUATION :
REMARKS : _____

_____

_____

DATE : _____ SIGNATURE _____

POLICYHOLDER'S (PERSONNEL APPROVAL :

SUM INSURED : _____

CLASS : _____

SIGNATURE : _____

TITLE : _____

STAMP :

INSURER'S USE ONLY :

EFFECTIVE DATE : _____

DEPENDENTS' COVER : _____

LOCATION OF DEPENDENTS : _____

CERTIFICATE NO. : _____

APPROVED BY : _____