

APPLICATION FOR INFORMATION CHANGING

Name of Policyholder: _____

Policy No.: _____

Request	Current	New updated
I. Related to policy/ policyholder:		
<input type="checkbox"/> Change of policyholder/ Change of policyholder name (*)	_____	_____
<input type="checkbox"/> Change address	_____	_____
<input type="checkbox"/> Change email address	_____	_____

II. Related to Insured person(s):
Please write full name and member number of Insured person(s) (attach additional sheets of paper if there is not enough space provided)

<input type="checkbox"/> Transfer policy (*) <i>Please provide the Policyholder name and Policy number (if any)</i>	_____	_____
<input type="checkbox"/> Change name <i>Please attached the copy of Identification Card/ Passport and legal documents related to this changing</i>	_____	_____
<input type="checkbox"/> Change occupation	_____	_____
<input type="checkbox"/> Other changes (if any)	_____	_____

Please provide work description. Ex: office/ administration, retail/ trading duties/ light manual labour, etc.

III. Change signature of

Insured person. Full name: _____

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Policyholder

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I hereby confirm that, the new signature will be applied for all applications, forms and documents related to my Healthcare Insurance Policy Package from the date of change request. The old signature remains valid for all applications, forms and documents which were signed before this date.

I, policyholder, hereby declare that, to the best of my knowledge and belief, all information is correct and true. This application and all attachments will be a part of the Healthcare Insurance Policy Package.

Signature & name of Policyholder: _____ Date: _____
(dd/mm/yyyy)

(* In case "Change of Policyholder/ Change of policyholder name" and "Transfer policy", signature and name of Policyholder is the signature and name of new updated Policyholder