

## Change in Insured Status Form

**IMPORTANT INSTRUCTIONS:** (please read them first)

- I- Please use this form if you want to **1** DELETE employees and/or their dependents from the insurance coverage, or **2** CHANGE Benefit Plan of the employees.
- II- Filled forms should be sent to: Policy Administration-Enrollment, Allianz EFU Health Insurance Ltd., D-136, Block-4, Clifton, Karachi (fax # 021-586-4020).
- III- In order for us to provide You with a fast and efficient service, please complete the Form accurately in 'CAPITAL LETTERS' and attach all necessary documents as mentioned below. Photocopies of this form can also be used.
- IV- Deletion/Change Benefit Plan of insured members should be done within 30 days of the eligibility.
- V- If you have any difficulty in filling this form, please call our Customer Relation Dept. at 111-HEALTH (021-111-432584).

**To Be Completed by the Plan Administrator/Employer:**

Name of the Policy Holder:  Policy Number:

Correspondence Address:

Please provide us the details of the insured member(s) whose status is to be changed:

**DELETIONS:** Please return the original HealthCard to us. (please use additional forms, if necessary)

S.No.	NAME OF THE EMPLOYEES/DEPENDENT	CERT. ID NUMBER(if any)	DATE OF BIRTH (dd/mm/yy)	RELATIONSHIP WITH THE EMPLOYEE	REASON FOR DELETION	EFFECTIVE FROM/DATE
1						
2						
3						
4						
5						
6						
7						

**BENEFIT PLAN CHANGE:** Please return the HealthCard to us for re-issuance. (please use additional forms, if necessary)

S.No.	NAME OF THE EMPLOYEE	CERT. ID	EXISTING BENEFIT PLAN	NEW BENEFIT PLAN	REASON FOR REVISION	EFFECTIVE FROM/DATE
1						
2						
3						
4						

Signature & Seal of Authorised Officer of the Employer \_\_\_\_\_ Date \_\_\_\_\_