

## **Change in Covered Member Status Form**

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

- Please use this form if you want to **1 DELETE** employees and/or their dependents from the takaful coverage, or 2 CHANGE Benefit Plan of the employees.
- II- Filled forms should be sent to: Policy Administration, EFU Life Assurance Ltd-Health Office, 37-K, Block-6, PECHS Society, Karachi or you may email us @ underwriting@efulife.com
- 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 covered members should be done within 30 days of the eligibility.
- V- If you have any difficulty in filling this form, please call our Call Center at 111-HEALTH (021-111-HELP-00).

Name of the Policy Holder:  Correspondence Address:  Please provide us the details of the covered 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  NUMBER (if any)  DATE OF BIRTH THE EMPLOYEE  DELETION  THE EMPLOYEE  DELETION  DATE  PREASON FOR DELETION  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 NEW BENEFIT PLAN  BENEFIT PLAN  REASON FOR DELETION  PREASON FOR REVISION  DATE  PRESCRIPTION  DATE  PRESCRIPTION  PRESCRIPTION  PRESCRIPTION  PRESCRIPTION  PRESCRIPTION  PREVISION  PRESCRIPTION  DATE  PREVISION  PREVISION  PREVISION  PREVISION  PREVISION  DATE	Correspondence Address:  Please provide us the details of the covered 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  NUMBER (if any)  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)  BENEFIT PLAN CHANGE: Please return the HealthCard to us for re-issuance. (please use additional forms, if necessary)  REASON FOR DELETION  S.No.  NAME OF THE EMPLOYEE  CERT. ID  EXISTING BENEFIT PLAN  REASON FOR REVISION  REASON FOR REVISION	
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## EFU LIFE ASSURANCE LTD. WINDOW TAKAFUL OPERATIONS

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