Change in Insured Status Form

IMPORTANT INSTRUCTIONS: (please read them first)

I- Please use this form if you want to ❶ **DELETE** employees and/or their dependents from the insurance coverage, or ❷ **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 insured 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).

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:

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 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 DATE
1						
2						
3						
4						

Signature & Seal of Authorised Officer of the Employer _____ **Date** _____

EFU LIFE ASSURANCE LTD.

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