BARAKA INSURANCE
we protect you

MEMBER DELETION/DEPENDANT DROP FORM

INSTRUCTIONS:

1. This Form use for **DELETION** of the Existing Member and/or his/her Dependents from Baraka Ins.
2. Application Form must be **signed** and **stamped** by your **HR/Admin Manager** where indicated.

1. CHANGE REQUEST

Request For (Please Select) ☐ **Deletion Members** ☐ **Dropping Dependants**										
With Effect From:	D	D	M	M	Y	Y	Y	Y		
Reason For DELETION Members (Please Select)									**Reason For DROPPING Dependants** (Please Select)	
	Left Employment									Divorce
	Lay off									Death
	Others (Pls. Explain)									Others (Pls. Explain)

2. DELETION MEMBER/DROPPING DEPENDANT INFORMATION

No:	Full Name	Membership No	No. of Dependents (When Principal Member Deletion)	Medical Cards Collected
1				**Yes**
2				Yes
3				**Yes**
4				Yes
5				**Yes**

3. DELETION/DROPPING TERMS AND CONDITIONS

i. Principal Member Deletion request automatically deleted all dependents of respective members.
ii. Dropping dependents for others reason will be applicable subject to BTI acceptance.
iii. BTI will arrange to adjust Pro-rata Unutilized Premium for such Employee (and the Insured Dependents) after 90 days from deletion/dropping date.
iv. Medical Card must be returned to the BTI Office on cessation of coverage of members and dependents.
v. USD 25 will be charged for unreturned card/ failure to return card.
vi. Any utilization of the card to access healthcare services thereafter will result in the insured person, whose cover has been terminated, and the organization being liable in respect of the cost of such claims.
vii. Employer will be liable for any related undue Claims under the Hold Harmless Clause of the Health Insurance/Medicare Baraka Policy Contract.
viii. No premium shall be refunded in respect of any outgoing Member who has enjoyed any claim under the plan.

4. DECLARATION

I, the undersigned on behalf of my organization understood the deletion/dropping terms and condition. I am obliged to return the medical card to the BTI office.

Stamp of Employer (Mandatory)

Signature of Authorized Person of Employer

Date: **Full Name:**

Principal Member Sign Required, when Dropping Dependent:

Date

Signature of Principal Member