NOOR TAKAFUL نور للتكافل

APPLICATION FOR TAKAFUL HEALTH CARE CARD

(Please use separate forms for each covered member)

PHOTOGRAPH

(Please Use Glue/Tape)

Date of Application

2 0 0

(DD/MM/YYYY)

Company Name

Employee Name

Employee Gender: [ ] Male [ ] Female

(Please fill in the details of the Primary Member)

Dependent Name

(Please fill in for addition of dependants for existing Primary Member)

Medical Card No. of Primary Member

Passport/ID Number

Date of Birth

(DD/MM/YYYY)

Relations (Please use tick (✓) mark, if others please specify)
Self/Husband/Wife/Son/Daugther _____

Authorization:

I hereby authorize _____ and /or Noor Takaful Family (PJSC) to have access to my medical records available in hospitals and clinics in the United Arab Emirates or outside the United Arab Emirates as and when it deems necessary.

Employee/Covered Person's Name & Signature

_____

To be filled in by Noor Takaful Family (PJSC)

Application received:

Card Issued:

Remarks:

_____

_____