

# American University of Sharjah



## Human Resources Department

### Group Life Policy Cover – Beneficiary Form

Highly confidential

I, the undersigned hereby authorize the American University of Sharjah to pay full amounts payable under the above policy and **\*additional benefit rider** to the following beneficiaries only and to be settled as under.

Name of employee : \_\_\_\_\_ A.U.S. I.D. : \_\_\_\_\_

Date of joining : \_\_\_\_\_

Nationality : \_\_\_\_\_

No.	Name of Beneficiary	Relationship	Share	Tel/ E-mail address
—	_____	_____	_____	_____
—	_____	_____	_____	_____
—	_____	_____	_____	_____
—	_____	_____	_____	_____
—	_____	_____	_____	_____
—	_____	_____	_____	_____

Name of employee \_\_\_\_\_

Witness \_\_\_\_\_

Signature \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Company official signature and stamp \_\_\_\_\_

\* 4 times annual salary in case of accidental death

\* Passport copy of each beneficiary is required