



AMERICAN UNIVERSITY OF SHARJAH
Human Resource Services
Life/Medical Insurance Application Form

Attach 1 passport size photograph for self and each dependent, if any

TO BE COMPLETED BY EMPLOYEE

PLEASE PRINT IN BLOCK LETTERS

Employee ID		Name		
Nationality	Date of Birth	Gender	Marital Status	Insurance ID #
		F <input type="checkbox"/> M <input type="checkbox"/>	S <input type="checkbox"/> M <input type="checkbox"/>	

DEPENDENTS INFORMATION

No.	Dependent's Name	Date of Birth	Relationship	Nationality
1				
2				
3				
4				
5				
6	«Other Allowances»			

Life Insurance		Plan				
Yes <input type="checkbox"/>	No <input type="checkbox"/>	I <input type="checkbox"/>	II <input type="checkbox"/>	III <input type="checkbox"/>	IV <input type="checkbox"/>	V <input type="checkbox"/>

***please attach passport copy showing UAE visa and 1 photograph for each individual**

Employee Signature _____

Date _____

TO BE COMPLETED BY HR DEPT.

Effective Date	Deductible amount (AED)		
Mon / Day / Year	50 <input type="checkbox"/>	60 <input type="checkbox"/>	70 <input type="checkbox"/>
	Grades: =<6	7-9	=>10

Comments:

Approved by HR _____

Stamp _____

Date _____

CHECK ON BANNER UPDATE

PDABENE	PDAEDN = LIF/ME1-5/MAT	PYINMED	PYCAFMB
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