



**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

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

DEPENDENTS INFORMATION

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

**\*please attach passport copy and 1 photograph for each individual**

I the undersigned acknowledge that the above information is correct and kindly request you to apply for myself/family insurance coverage and card(s) accordingly.

\_\_\_\_\_  
**Employee Signature** \_\_\_\_\_  
**Date**

TO BE COMPLETED BY HR DEPT.

<b>Effective Date</b>	<b>Deductible amount (AED)</b> 50 <input type="checkbox"/> 60 <input type="checkbox"/> 70 <input type="checkbox"/>	<b>Monthly Base Pay (AED)</b>	<b>Plan I or II</b> I <input type="checkbox"/> II <input type="checkbox"/>
<b>Effective Date</b>	<b>Premium adj. amt Plan I ME1</b>	<b>Premium adj. amt Plan II ME2</b>	<b>Maternity adj. amt MED</b>

Note: Plan I = Cover in UAE, Arab Countries, S.E. Asia and covered for emergency worldwide. Plan II = Covers worldwide.

\_\_\_\_\_  
**Approved by HR** \_\_\_\_\_  
**Stamp** \_\_\_\_\_  
**Date**

CHECK ON BANNER UPDATE

<b>PDABENE</b>	<b>PDAEDN = LIF/ME1/ME2/MAT</b>	<b>Banner update by</b>	<b>DATE</b>
<b>PYINMST</b>	<b>Co-Payment set-up for Plan II = MED Adult = US\$ 160 = US\$ 110</b>		