UNITED HEALTH INSURANCE LIMITED
REMOVE DEPENDENT(S)

Cnr, Mahleka and Masalesikhundleni Streets
P.O.Box 114, Manzini M200 Tell: 2508 6000 Fax 2404 7541

MEMBERSHIP NUMBER:																			
Title		**Surname**													**Option**				
Full First Names																			
Identity Number/ Passport Number																**Gender**	M	F	
Telephone	**Cell:**														**Work:**				
Reply by	**Fax**	**E-mail**													**Employee Number**				
Employer																			
REMOVE DEPENDENTS																			
Name															**Date of Birth**				
	Remove	SPOUSE	CHILD	M	F	Y	Y	Y	Y	M	M	D	D						
	Remove	SPOUSE	CHILD	M	F	Y	Y	Y	Y	M	M	D	D						
	Remove	SPOUSE	CHILD	M	F	Y	Y	Y	Y	M	M	D	D						
	Remove	SPOUSE	CHILD	M	F	Y	Y	Y	Y	M	M	D	D						
	Remove	SPOUSE	CHILD	M	F	Y	Y	Y	Y	M	M	D	D						
Member Signature					**Date of Signature**														

Please Note:

1. Please provide United Health Insurance with a copy of the dependents ID.
2. No money will be refunded if you removed a dependent.
3. Your request is subject to a 30 day notice period.

Please complete the request information on the form and on the Health Questionnaire and fax/e-mail it back to:

E-mail: uhienquiries@united.com

FOR OFFICE USE ONLY										
Received By		**Date Received**	d	d	m	m	y	y	y	y
Captured By		**Date Captured**	d	d	m	m	y	y	y	Y
Underwriter		**Date**	d	d	m	m	y	y	y	y
Underwriter	Signature	**Approved**	Yes		No					
If no, explain:										

PLEASE RETURN COMPLETED FORM TO:

Dups Mall, Plot 105, Cnr Mahleka & Masalesikhundleni Streets, Manzini Swaziland
P.O. Box 114 Manzini, M200, or uhienquiries@united.com