

**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.

Disclaimer:

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If you have received this information in error, please notify the sender immediately, and delete this email from your system.

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 uhenquiries@united.com

