



REMOVAL OF BENEFICIARIES

PLEASE PRINT / WRITE ALL INFORMATION IN CAPITAL LETTERS

COMPANY NAME:

No.	MEMBERSHIP NUMBER	FULL NAME
1		
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COMPANY AUTHORIZATION

We hereby undertake that in the event that any member listed above accesses health care with the membership card hereafter,

.....shall bear the full cost of medical care with applicable administrative charges related to such use of the card.
(COMPANY NAME)

Name _____ **Signature** _____

Designation: _____ **Date:** _____

Stamp :