Office of Human Capital Management

Request Form for Outdoor Medical Coverage

- Parents, Spouse and Children are **covered** under outdoor medical coverage
- Son shall be covered **till 25 years of age**
- Daughter shall be covered **till marriage**

Employee Name:____ Employee Code: ____________________________

Designation:____ Date of Joining: ____________________________

School/Office:____ CNIC # __________________________________

Employee DOB: ____

Sr. #	Name of Dependent (Parents/Spouse/Children)	Relation with Employee	Date of Birth
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Applying for:

Self only ☐ Self & Family ☐ Dependents only ☐

Note: Please attach <u>one photograph each (size 1"x1") of yourself and your dependents in blue background</u> with this form. Kindly write the concerned person's name on the back side of the photographs. Attach Copy of National Identity of yourself and dependents, and in case of children's, attach copy of B.Form.

Applicant's Signature: __________________________ *Date:* ___________________

For Office Use only

Employee Status: _____________________ *Received by:* _____________________ *Date:* ____________________