Office of Human Resources

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 # _____

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 one photograph each (size 1"x1") of yourself and your dependents in blue background with this form. Kindly write the concerned person's name on the back side of the photographs.

Applicant's Signature: _____ *Date:* _____

For Office Use only

Employee Status: _____ *Received by:* _____

Date: _____