CORPORATE MEMBERSHIP FORM

Company Name

Postal Address

Locational Address

Tel No(s)

Fax

Primary Contact Person

Email

Nature of Business

Total Number of Employees

Number of Members To Be Covered

PLANS	NO. OF PRINCIPAL MEMBERS	NO. OF DEPENDENTS
SMARTCARE		
MAXCARE		
MAXCARE PLUS		
ROYALCARE		
TPA		

Commencement Date

Payment Type (Please Tick)

Quarterly ☐ Biannually ☐ Annually ☐

I hereby declare that to the best of my knowledge, the above information is true and accurate

Sign

Name

Job Tittle

Date