



REQUEST FOR AMENDMENT FORM

This is to request amendment of Health Care Agreement under **Membership Card Number (MCN)** _____. I agree that this Application and my declarations and answers below, written by me or under my direction, shall be deemed part of the contract between CHSI and myself.

Last Name	First Name	Suffix Name	Middle Name	Mother's Maiden Surname
Landline Number	Mobile Number		Email address	

AMENDMENT REQUEST: Check (✓) the box for the desired amendment and accomplish the change/s in the appropriate column (FROM – TO)

FOR CHANGES IN MEMBER'S INFORMATION

FOR TRANSFER OF PLAN DUE TO DECEASED MEMBER

1. Change of Marital Status / Surname / Annulment of Marriage

Basic Requirements:

- Photocopy of Marriage Certificate
- Court Approved Copy of Annulment
- Latest two (2) valid government IDs with three (3) specimen signatures

Basic Requirements:

- Photocopy of Death Certificate of Member
- Photocopy of any valid ID of the Member
- Photocopy of two (2) valid government IDs of Beneficiary/ies designated by the Member in the plan with three (3) Specimen signatures
- Notarized Waiver of Rights (if multiple beneficiaries)

2. Any change/s in name or other personal information

Basic Requirements

- Photocopy of Birth Certificate
- Notarized Affidavit of Two Disinterested Persons
- Latest two (2) valid government IDs with three (3) specimen signatures
- Other supporting documents

FROM	TO

I understand that this request for Amendment is subject to evaluation of Caritas Health Shield, Inc. (CHSI) and I agree that all amendment/s approved by CHSI shall be deemed part of the Health Care Agreement.

In witness whereof, I have signed this request at _____, Philippines on the _____ day of _____, _____.

Printed Name and Signature of Member

Signature over Printed Name of Parent/Guardian / Authorized Representative
(If member is below 18 years old)