

## REPLACEMENT OF IDENTIFICATION CARD FORM (RIDC05)

COMPANY NAME, *if applicable*

NAME *Mr. / Mrs. / Ms.*

RESIDENTIAL ADDRESS *(Please include P.O.Box)*

TELEPHONE NO. 1  TELEPHONE NO. 2

E-MAIL

NAME OF HOSPITAL

NUMBER OF CARDS TO BE REPLACED

### Circumstances regarding your identification card *(Please tick the box applicable to you)*

Identification card has become invalid  *(Please attach invalid card to this form)*

Identification card was stolen

Identification card is misplaced/ lost

Identification card has been damaged  *(Please attach damaged card to this form)*

Other circumstances

Signature of Principal Enrollee \_\_\_\_\_  
On behalf of all beneficiaries

Date \_\_\_\_\_

FOR OFFICIAL USE ONLY *(Please leave blank)* CL/ / / /