

CLIENT SERVICES UNIT MEDICAL HEALTH STATUS DISCLOSURE

Membership Number

Date:

Member's Name (Principal)

Telephone Number

Email Address

Furtherance to my membership application document with FamilyCare Funeral Trust Ltd., I wish to amend the health status of the underlisted Member(s) as follows;

Name	Illness	Duration of Illness	Health Care Provider

I further declare that all information provided are true and accurate.

Signature of Client

Date

OFFICE USE ONLY

Handled By

Signature

Date