LIGHTHOUSE CLUB INTERNATIONAL – MEDICAL BENEFITS APPLICATION FORM	
Lighthouse Club Branch:	
Name:	
Date of birth:	
Male/Female:	
Nationality:	
Country of residence:	
Contact email:	
Contact mobile:	
Please note if you need dental and/or maternity coverage:	
If you're looking for coverage for your family, please state their names, DOB and their sex:	
Date:	

Once completed, please send to Kevin Ch'ng at kevin.chng@sjpp.asia or call +852 9854 7765