

MelitaUnipol Insurance Agency Ltd

17 Market Street Floriana FRN1081

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**AMENDMENT FORM
USE THIS FORM TO CHANGE YOUR POLICY**

DATE _____

POLICY No _____ CLIENT ACCOUNT No _____

NAME _____ I.D. No _____

TEL No _____ FAX No _____

KINDLY EFFECT THE FOLLOWING AMENDMENT WITH EFFECT FROM:

DATE _____ TIME _____

IN THE EVENT OF A CANCELLATION OF THE POLICY THE ORIGINAL POLICY OF INSURANCE MUST BE RETURNED TO OUR OFFICES. IF ORIGINAL POLICY IS NOT RETURNED PLEASE JUSTIFY REASON ABOVE.

INSURED'S SIGNATURE

PRODUCERS'S SIGNATURE