Form V

NATIONAL HEALTH INSURANCE
VOLUNTARY CONTRIBUTOR MONTHLY REMITTANCE FORM

(A) LAST NAME: _____ FIRST NAME: _____

(B) REGISTRATION NUMBER: _____ VOLUNTARY CODE: _____

CONTRIBUTION MONTH	INSURABLE EARNINGS	CONTRIBUTION AMOUNT 7½%	COMMENTS

Signature …… Date: D____ M_____ Y _____

OFFICIAL USE ONLY

Cashier: _____ Receipt No. _____ Date: D____ M____ Y ____ Verified: _____

Posted: _____ Date: D____ M____ Y ____ Checked: _____