GREEN FIELD HEALTH MANAGEMENT LIMITED

(Health Maintenance Organization)

CHANGE OF HOSPITAL FORM

INSTRUCTION: (I) USE Biro Only. (II) Write in Block (Capital) Letters. (III) Any Information Not Available NOW, Write "N/A"

Personal Data:

Employer's Name _____ **GFHML IDENTIFICATION NUMBER** _____

Mr. /Mrs. /Ms. Surname _____ **First Name** _____ **Middle Name** _____

E-mail Address _____

Telephone Number(s) _____ **Residential Address (Not P.O. Box or P.M.B)** _____

_____ **National Identity Number (NIN)** _____

*** Please do not complete if only dependants are requesting for a change of hospital**

Name of Current Provider _____

Location _____

Name of Preferred Provider _____

Location _____

Reason For Change

.....

.....

.....

.....

*** Please complete for your spouse and dependants only**

	First Name & Middle Name	Date of Birth	Sex	Blood Group	Hb Genotype	Pre-existing condition
Spouse						Yes/No
Child 1						Yes/No
Child 2						Yes/No
Child 3						Yes/No
Child 4						Yes/No

* **Choice of Hospital**: Same as Principal ☐ , Other (Please Specify) _____

State of Location _____

* Pre-existing condition, (If **Yes**) specify _____

Declaration: I hereby apply to be enrolled in the plan together with the persons to be insured listed above. I declare that to the best of my knowledge on behalf of all persons to be insured under this application that I have read and understand completely the policy exclusions and conditions. It is agreed that this declaration and information given in this application shall form the basis of the contract(s) between the insured person(s) and the HMO. Any false information provided in respect of the medical profile of the insured, invalidates the policy.

Principal Enrollees' Signature (*on behalf of all beneficiaries*)..... Date.....