GREEN FIELD HEALTH MANAGEMENT LIMITED

(Health Maintenance Organization)

Private Sector Social Health Insurance Programme (PSSHIP)

ENROLLEE'S REGISTRATION FORM

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

Employee's Personal Data:

☐ **Surname** **First Name** **Middle Name**

Date of Birth **Sex (M/F)** **Marital Status (S/M/D/SP)** **Blood Group** **Hb Genotype**

Occupation **Designation** **E-mail Address**

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

National Identity Number (NIN)

Employer's Data

Name: Telephone Number

Address: E-Mail

Branch Office Town State

Primary Provider Data (Hospital)

Name of Hospital:

GFHML Health Plans *(please tick policy coverage and type of plan (individual or family)*

Diamond............................. ☐

Gold.................................. ☐

Classic.............................. ☐

Standard............................ ☐

Basic .... ☐

Individual Plan...................... ☐

Family Plan......................... ☐

Medical History of Principal Enrollee

(Medical condition that has been diagnosed which can be life threatening to the enrollee)

Diabetes ☐ **Epilepsy** ☐ **Sickle Cell Diseases** ☐ **Allergies** ☐ **RVD** ☐ **Hypertension** ☐

Others (Please Specify)

	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

***Is the Principal or Spouse Pregnant (Yes/No)**

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

PRINCIPAL AFFIX PHOTOGRAPH	SPOUSE AFFIX PHOTOGRAPH	CHILD 1 AFFIX PHOTOGRAPH	CHILD 2 AFFIX PHOTOGRAPH	CHILD 3 AFFIX PHOTOGRAPH	CHILD 4 AFFIX PHOTOGRAPH

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.

Employee's Signature *(on behalf of all beneficiaries)*............................ Date..................................