GREEN FIELD
HEALTH MANAGEMENT LTD

Plot 14 Market Garden Pocket Layout,
Isiadinson Close, G.R.A., Enugu
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ENROLLEE'S REGISTRATION FORM

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

PERSONNEL DATA:

☐ Surname | First Name | Other Names

Date of Birth | Sex (M/F) | Marital Status (S/M/D/SP) | Country of Birth | Nationality

Phone Number | Email Address | National Identity Number (NIN)

Residential Address (Not P. O. Box or P.M.B) | Town/City

Local Government Area (L.G.A.) | State of Residence | Country of Residence

Postal / Zip Code | State of Origin | Country of Origin

Occupation | Organization / Employer

HEALTH BENEFIT PLANS

(please tick policy coverage)

☐ Diamond ☐ Gold ☐ Classic ☐ Standard ☐ Basic ☐ Others .....

TYPE OF PLAN

(individual or family)

☐ Individual ☐ Individual & Child(ren) ☐ Individual & Spouse ☐ Family

PRIMARY PROVIDER DATA (HOSPITAL):

Name of Hospital

PRE-EXISTING MEDICAL CONDITIONS:

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

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

Others (Please specify)

ADD	DELETE	LAST NAME	FIRST NAME	OTHER NAMES	SEX	DATE OF BIRTH	RELATIONSHIP	PRE-EXISTING CONDITIONS
☐	☐							
☐	☐							
☐	☐							
☐	☐							
☐	☐							

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

..... **Enrollee's Signature/Thumbprint**

..... **Date**