***Healthcare International***

**ENROLLEE FORM**

*PLEASE FILL IN BLOCK LETTERS*

| Click here to add photo | Click here to add photo | Click here to add photo | Click here to add photo | Click here to add photo | Click here to add photo |
|---|---|---|---|---|---|
| Passport Photo | Spouse | Dependant 1 | Dependant 2 | Dependant 3 | Dependant 4 |

SURNAME | MIDDLE NAME | OTHER NAME

ADDRESS

OCCUPATION | DESIGNATION

PHONE NUMBER (mobile) | (Fixed) | Email Address

| | |
|---|---|
| PLAN TYPE | |
| HOSPITAL OF CHOICE | |
| ALLERGIES | |

SEX | DATE OF BIRTH-dd/mm/yyyy | GENOTYPE | BLOOD GROUP

NAME OF EMPLOYER

ADDRESS OF EMPLOYER

*SPOUSE*

SURNAME | MIDDLE NAME | OTHER NAME

ADDRESS

OCCUPATION | DESIGNATION

PHONE NUMBER (mobile) | (Fixed) | Email Address

SEX | DATE OF BIRTH-dd/mm/yyyy | GENOTYPE | BLOOD GROUP

| | |
|---|---|
| PLAN TYPE | |
| HOSPITAL OF CHOICE | |
| ALLERGIES | |

PAST MEDICAL HISTORY

Do you or have you ever suffered from any of the following ailments? If so please indicate.

(a) Hypertension (b) Diabetes Mellitus
(c) Duodenal Uleer (d) Sickle Cell Disease
(e) Glaucoma (f) Heart Disease
(g) Kidney Disease (h) Epilepsy
(i) Asthma (j) Tuberculosis
(k) HIV/AIDS

| | CONDITION SUFFERED | WHEN |
|---|---|---|
| | | |
| | | |
| | | |

Have you ever had a surgical operation?

If yes, what type of surgery was it and when?

Please state any other relevant information you would like us to have concerning your health

## DEPENDANT 1

SURNAME | MIDDLE NAME | OTHER NAME

SEX | DATE OF BIRTH-dd/mm/yyyy | GENOTYPE | BLOOD GROUP

ALLERGIES

HOSPITAL | RELATIONSHIP

## DEPENDANT 2

SURNAME | MIDDLE NAME | OTHER NAME

SEX | DATE OF BIRTH-dd/mm/yyyy | GENOTYPE | BLOOD GROUP

ALLERGIES

HOSPITAL | RELATIONSHIP

## DEPENDANT 3

SURNAME | MIDDLE NAME | OTHER NAME

SEX | DATE OF BIRTH-dd/mm/yyyy | GENOTYPE | BLOOD GROUP

ALLERGIES

HOSPITAL | RELATIONSHIP

## DEPENDANT 4

SURNAME | MIDDLE NAME | OTHER NAME

SEX | DATE OF BIRTH-dd/mm/yyyy | GENOTYPE | BLOOD GROUP

ALLERGIES

HOSPITAL | RELATIONSHIP

## DECLARATION

I hereby declare that all information given above are all true to the best of my knowledge and that I have not concealed or witheld any information. I also agree to abide by the terms and conditions of the Healthcare Scheme.

Click here to add signature

Signature

DATE


**HEALTHCARE INTERNATIONAL**

**Head Office:**
308A Murtala Mohammed Way, Yaba, Lagos.
Tel: 4705701,4755701,4755702,4755703

**Port Harcourt Office:**
Riz Plaza Plot 19, Stadium Road,
By Melvon Gas Plant, Off Elekahia Port Harcourt
Tel: 084-571616, 084-777897 Fax: 084-233263.

**Abuja Office:**
UAC Commercial Complex, (3rd Floor)
Central Business District, Abuja - F.C.T.
Tel: 09-6709099 Fax: 09-5238589.

Email: info@healthcare-ng.com