Healthcare International

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ENROLLEE FORM (Individual)

PLEASE FILL IN BLOCK LETTERS

SURNAME: FIRST NAME: OTHER NAMES:

ADDRESS:

CITY: STATE: PHONE NO:

OCCUPATION: DESIGNATION: email:

Date Of Birth: SEX: GENOTYPE: BLOOD GROUP:

EMPLOYER:

EMPLOYER'S ADDRESS:

PLAN TYPE: RELIGION: ALLERGIES:

HOSPITAL OF CHOICE:

PAST MEDICAL HISTORY

Do you or any member of your family suffer (or had suffered) fro any of the following ailment?If so indicate the name and condition(s) appropriately

- ☐ Hypertension
- ☐ Asthma
- ☐ Heart Disease
- ☐ Duodenal Ulcer
- ☐ HIV/AIDS
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Diabetes Mellitus
- ☐ Tuberculosis
- ☐ Kidney Diseas
- ☐ Sickle Cell

Have you ever had a surgical operation?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?

Waiting Period and limitations

1. There is a waiting period of 14 days after receipt of your duly completed form and photographs before you can visit your hospital of choice.
2. All non-emergency surgeries are subject to pre- authorization.

3. Maternity care: There is a waiting period of One (1) year after plan commencement before you can enjoy access to maternity care.
4. Chronic conditions: These conditions such as hypertension, diabetes mellitus, bronchial asthma, etc, which cause you to be on regular prescribed medication, will only be covered after one year from date of diagnosis, provided that the illness started and was diagnosed while on the scheme.

Terms of Subscription for individual (non-group) plan

Plan Period: One year from commencement date, renewable yearly

Eligibility: 0 - 65 years of age

Exclusions: The following conditions are not covered under the scheme:

a. Medical services not included in selected plan.
b. Pre-existing conditions: any medical condition that existed prior to commencement date such as hypertension, diabetes, asthma etc.
c. Alternative medical treatment, nutritional supplements.
d. Cosmetic treatments.
e. Secondary and tertiary dental care.
f. Obesity, infertility, impotence, prosthesis, artificial limbs.
g. Cancer and other chronic conditions.
h. Chronic renal dialysis
i. major surgeries to head, spinal cord as well as organ transplants.
j. Treatment of psychiatric conditions.
k. HIV/AIDS and related conditions.
l. Injuries resulting from Suicide attempts.
m. Injuries resulting from Domestic violence.
n. Medical treatment from outside the Fedal Republic of Nigeria.

Declaration

I, _____ hereby declare that all information given above are true to the best of my knowledge and that I have not concealed or withheld any information. I have also read and understood the above and declare that the terms are acceptable to me. I agree that Healthcare International shall not be liable for any claims that arise from conditions or treatments contrary to the above terms. I authorize any medical practitioner or organization having medical information concerning me/us to provide such information to Healthcare International.

Signature: _____ Date: _____

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