



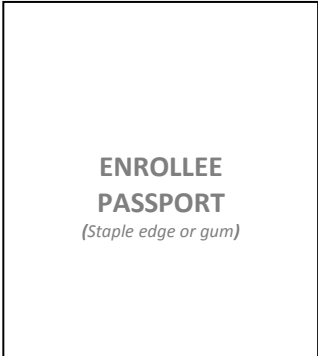
# ProHealth HMO LIMITED

NO 62, LOBITO CRESCENT, OFF ADEMOLA ADETOKUNBO, WUSE II, ABUJA.

## ENROLLEE APPLICATION FORM

### COMMUNITY BASED SOCIAL HEALTH INSURANCE PROGRAMME

Please complete in **block letters**, tick (✓) in appropriate boxes and append your passport Photograph and return to ProHealth HMO Ltd.



#### SECTION A

<b>SURNAME:</b>	
<b>FIRST NAME:</b>	
<b>OTHER NAME:</b>	

<b>CONTACT ADDRESS</b>			
<b>SEX</b>	<b>DATE OF BIRTH</b>	<b>GENOTYPE</b>	<b>BLOOD GROUP</b>
Male <input type="checkbox"/> Female <input type="checkbox"/>	DD/MM/YYYY	AA <input type="checkbox"/> AS <input type="checkbox"/> SS <input type="checkbox"/> SC <input type="checkbox"/>	O+ <input type="checkbox"/> O- <input type="checkbox"/> A+ <input type="checkbox"/> A- <input type="checkbox"/> B+ <input type="checkbox"/> B- <input type="checkbox"/> AB+ <input type="checkbox"/> AB- <input type="checkbox"/>
<b>NAME OF COMMUNITY / ASSOCIATION</b>			
<b>PHONE NUMBER</b>		<b>E-MAIL ADDRESS</b>	
<b>OCCUPATION</b>			

#### SECTION B

#### PAST MEDICAL HISTORY

Do you, or have you ever suffered from any of the following ailments? If so, please indicate			
Hypertension <input type="checkbox"/>	Duodenal ulcer <input type="checkbox"/>	<b>CONDITION SUFFERED</b>	<b>WHEN</b>
Glaucoma <input type="checkbox"/>	Asthma <input type="checkbox"/>		
Kidney disease <input type="checkbox"/>	Diabetes <input type="checkbox"/>		
Sickle cell disease <input type="checkbox"/>	Heart disease <input type="checkbox"/>		
Epilepsy <input type="checkbox"/>	Tuberculosis <input type="checkbox"/>		
HIV / AIDS <input type="checkbox"/>	Arthritis <input type="checkbox"/>		

Do you have Allergy(ies)? Yes  No . If yes, state: \_\_\_\_\_

Have you ever had a surgical operation? Yes  No . If yes, what type? \_\_\_\_\_

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

#### SECTION C

**FOR OFFICIAL USE ONLY**

**ENROLLEE NO:**