



ProHealth HMO LIMITED

BASSAN PLAZA, Block D, First Floor, Plot 759 Independent Avenue, Central Business District, Abuja.

ENROLLEE APPLICATION FORM

Please complete in **block letters**, tick (✓) in appropriate boxes and include passport photograph of each beneficiary and dependant and return to ProHealth HMO Ltd.

SECTION A

HEALTH PLAN OPTION	SAPPHIRE <input type="checkbox"/>	EMERALD <input type="checkbox"/>	RUBY <input type="checkbox"/>	DIAMOND <input type="checkbox"/>
TYPE	INDIVIDUAL <input type="checkbox"/>	FAMILY <input type="checkbox"/>		

SECTION B

PRINCIPAL

SURNAME	OTHER NAMES	SEX	DATE OF BIRTH DD/MM/YYYY	MARITAL STATUS
NATIONALITY	NAME OF ORGANIZATION			
MOBILE PHONE	GENOTYPE	BLOOD GROUP	EMAIL ADDRESS	
CONTACT ADDRESS			LOCATION / BRANCH	
HOSPITAL OF CHOICE (Please, Check the list of Hospitals as declared or visit www.prohealthhmo.com/hcp)				
BRIEF MEDICAL HISTORY e.g. Pre-existing condition				
HYPERTENSION <input type="checkbox"/> ASTHMA <input type="checkbox"/> DIABETES <input type="checkbox"/> SICKLE CELL <input type="checkbox"/> CANCER <input type="checkbox"/> AIDS <input type="checkbox"/> GLAUCOMA <input type="checkbox"/> PREGNANCY <input type="checkbox"/>				
PREVIOUS SURGERY(IES) & ALLERGY(IES): _____				

SECTION C

SPOUSE DETAILS

SURNAME:	OTHER NAMES:			
DATE OF BIRTH: DD/MM/YYYY	SEX: Male <input type="checkbox"/> Female <input type="checkbox"/>	BLOOD GROUP:	GENOTYPE:	
BRIEF MEDICAL HISTORY e.g. Pre-existing condition		MOBILE PHONE:		
HYPERTENSION <input type="checkbox"/> ASTHMA <input type="checkbox"/> DIABETES <input type="checkbox"/> SICKLE CELL <input type="checkbox"/> CANCER <input type="checkbox"/> AIDS <input type="checkbox"/> GLAUCOMA <input type="checkbox"/> PREGNANCY <input type="checkbox"/>				
PREVIOUS SURGERY(IES) & ALLERGY(IES): _____				

FIRST CHILD

SURNAME:	OTHER NAMES:			
DATE OF BIRTH: DD/MM/YYYY	SEX: Male <input type="checkbox"/> Female <input type="checkbox"/>	BLOOD GROUP:	GENOTYPE:	
BRIEF MEDICAL HISTORY e.g. Pre-existing condition				
HYPERTENSION <input type="checkbox"/> ASTHMA <input type="checkbox"/> DIABETES <input type="checkbox"/> SICKLE CELL <input type="checkbox"/> CANCER <input type="checkbox"/> AIDS <input type="checkbox"/> GLAUCOMA <input type="checkbox"/> SEIZURE DISORDER <input type="checkbox"/>				
PREVIOUS SURGERY(IES) & ALLERGY(IES): _____				

SECOND CHILD

SURNAME:	OTHER NAMES:			
DATE OF BIRTH: DD/MM/YYYY	SEX: Male <input type="checkbox"/> Female <input type="checkbox"/>	BLOOD GROUP:	GENOTYPE:	
BRIEF MEDICAL HISTORY e.g. Pre-existing condition				
HYPERTENSION <input type="checkbox"/> ASTHMA <input type="checkbox"/> DIABETES <input type="checkbox"/> SICKLE CELL <input type="checkbox"/> CANCER <input type="checkbox"/> AIDS <input type="checkbox"/> GLAUCOMA <input type="checkbox"/> SEIZURE DISORDER <input type="checkbox"/>				
PREVIOUS SURGERY(IES) & ALLERGY(IES): _____				

THIRD CHILD

SURNAME:	OTHER NAMES:			
DATE OF BIRTH: DD/MM/YYYY	SEX: Male <input type="checkbox"/> Female <input type="checkbox"/>	BLOOD GROUP:	GENOTYPE:	
BRIEF MEDICAL HISTORY e.g. Pre-existing condition				
HYPERTENSION <input type="checkbox"/> ASTHMA <input type="checkbox"/> DIABETES <input type="checkbox"/> SICKLE CELL <input type="checkbox"/> CANCER <input type="checkbox"/> AIDS <input type="checkbox"/> GLAUCOMA <input type="checkbox"/> SEIZURE DISORDER <input type="checkbox"/>				
PREVIOUS SURGERY(IES) & ALLERGY(IES): _____				

FOURTH CHILD

SURNAME:	OTHER NAMES:			
DATE OF BIRTH: DD/MM/YYYY	SEX: Male <input type="checkbox"/> Female <input type="checkbox"/>	BLOOD GROUP:	GENOTYPE:	
BRIEF MEDICAL HISTORY e.g. Pre-existing condition				
HYPERTENSION <input type="checkbox"/> ASTHMA <input type="checkbox"/> DIABETES <input type="checkbox"/> SICKLE CELL <input type="checkbox"/> CANCER <input type="checkbox"/> AIDS <input type="checkbox"/> GLAUCOMA <input type="checkbox"/> SEIZURE DISORDER <input type="checkbox"/>				
PREVIOUS SURGERY(IES) & ALLERGY(IES): _____				

SECTION D

NEXT OF KIN

NAME:	SEX:	RELATIONSHIP:
MOBILE NUMBER:	ADDRESS:	

SECTION E

Declaration

I _____, have carefully read and understood all the policy conditions and exclusions. I hereby declare that information supplied on this application form is true and complete and it shall be for the basis of contract between me and ProHealth HMO Ltd.

Signature of Principal Enrollee or Thumbprint / Date

Note: Subscribers to the scheme should note that the scheme commences 2 weeks after submission of properly filled form(s) and full payment of premium.

SECTION F

FOR OFFICIAL USE ONLY

ENROLLEE NO:

PH/

PRINCIPAL ENROLLEE
PASSPORT
(Staple edge or gum)

SPOUSE
PASSPORT
(Staple edge or gum)

FIRST CHILD
PASSPORT
(Staple edge or gum)

SECOND CHILD
PASSPORT
(Staple edge or gum)

THIRD CHILD
PASSPORT
(Staple edge or gum)

FOURTH CHILD
PASSPORT
(Staple edge or gum)