Prepaid Medicare Services
Health Maintenance Organization

PREPAID MEDICARE SERVICES (HMO 030)

ENROLEE DATA FORM

Please fill with (i) black ink (ii) capital letters

Use staple pin on/ to affix photograph

3cm x 3.5cm

1. Personal Data:

Surname | First Name | Middle Name

M F | Sex | Age | Date of Birth | Single Married | Marital Status: | Nationality

Residential Address (Not P.O.Box or P.M.B)

Telephone No.: Home | Telephone No.: Mobile | Occupation:

Blood Group | Rh | Next of Kin | Telephone No.: Mobile

2. Employer's Data :

Employer's Name:

Employer's Address:

MD= Management Staff
SS= Senior Staff
JS= Junior Staff
Employee's Position:

Employee's Location: State/Town

3. Preferred Plan:

Alpha Individual | Beta Individual | Omega Individual | Alpha Family | Beta Family | Omega Family

4. Nominated Hospital:

Primary Hospital

Hospital Address

5. Medical History of Significance

Have you or any of your family members have been diagnosed of any of the disease listed below? Please tick as appropriate

Sickle Cell Disease		Viral Hepatitis		Epilepsy		Tuberculosis		Arthritis			
Diabetes Mellitus		Kidney Disease		Glaucoma		Cancer		Haemorrhoids			
Hypertension		Asthma		HIV/AIDS		Chest Pain		Heart Disease			
Emphysema		Cataract		Goiter		Peptic Ulcer		Diarrhoea			

Any other Known Illness:

6. For Family Cover: One Spouse and 4 Biological Children under 18years

	First Name	Sex	Blood group	Date of birth	Any Known Illness /Allergy
(I) Spouse					
(ii) Child 1					
(iii) Child 2					
(iv) Child 3					
(V) Child 4					

Any alternative Primary Hospital?

Alternative Primary Hospital Name

Hospital Address

7. Premium Payment:

3 Months | 6 Months | One Year

8. Sales Agent:

Agent Name

Agent Signature

Date

Enrolee Signature

Date