Address: NDC Quarters No 45 Murtala Nyako Close Apo, Abuja.
Phone: 07036035182, 07066876862, 08131046227
Email: enrolment@ashmedhmo.com

ENROLMENT FORM

Kindly fill this form, scan and submit via Email: enrolment@ashmedhmo.com.
Call above phone numbers for any enquiries

"Liability of ASHMED INTEGRADTED HEALTH SERVICES does not commence until this application is accepted, premium received and policy issued. Please NOTE that benefits may not be payable if you do not fully disclose any material facts which could influence our assessment and acceptance of this application and if you are in any doubt as to whether any facts are material, you should disclose them. This applies even if medical advice has not been sought. A material fact is one that is likely to affect the assessment of this application.

Please tick as appropriate: **Individual** ☐ **Family** ☐ Policy Number: _____

Company Name: _____ Nature of Business: _____

If you're applying as a corporate entity, please insert name of the company above.

1. PERSONAL DETAILS (Principal)

Surname: _____ First Name: _____

Date of Birth: _____ Gender: _____ Marital status: _____

Occupation: _____

Genotype: _____ Blood Group: _____

Residential Address: _____

_____

Phone: _____ E- Mail: _____

PASSPORT

Name & Number of Next of Kin: _____

Preferred Hospital: _____

Address/Phone Number/E-mail of Preferred Hospital: _____

_____

2. SPOUSE DETAILS

Surname: _____ First Name: _____

Date of Birth: _____ Gender: _____ Marital status: _____

Occupation: _____

Genotype: _____ Blood Group: _____

Residential Address: _____

_____

Phone: _____ E- Mail: _____

PASSPORT

Name & Number of Next of Kin: _____

Preferred Hospital: _____

Address/Phone Number/E-mail of Preferred Hospital: _____

_____

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3. DEPENDANT 1

Surname: _____ First Name: _____
Date of Birth: _____ Gender: _____
Occupation: _____
Genotype: _____ Blood Group: _____ E-Mail: _____
Residential Address & Tel. No: _____
_____
Preferred Hospital and Phone number: _____
_____

PASSPORT

4. DEPENDANT 2

Surname: _____ First Name: _____
Date of Birth: _____ Gender: _____
Occupation: _____
Genotype: _____ Blood Group: _____ E-Mail: _____
Residential Address & Tel. No: _____
_____
Preferred Hospital and Phone number: _____
_____

PASSPORT

5. DEPENDANT 3

Surname: _____ First Name: _____
Date of Birth: _____ Gender: _____
Occupation: _____
Genotype: _____ Blood Group: _____ E-Mail: _____
Residential Address & Tel. No: _____
_____
Preferred Hospital and Phone number: _____
_____

PASSPORT

6. DEPENDANT 4

Surname: _____ First Name: _____
Date of Birth: _____ Gender: _____
Occupation: _____
Genotype: _____ Blood Group: _____ E-Mail: _____
Residential Address & Tel. No: _____
_____
Preferred Hospital and Phone number: _____
_____

PASSPORT

Kindly request extra form to register additional dependant(s)

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7. CATEGORY OF MEDICAL COVER (Please tick one box only)

TOPAZ ☐ SAPHIRE ☐ EMERALD ☐ RUBY ☐ DIAMOND ☐

8. COMMENCEMENT DATE: dd | mm | yyyy
(Date you want cover to commence)

9. PREMIUM PAYABLE: _____

10. METHOD OF PAYMENT: CHEQUE ☐ CASH ☐ TRANSFER ☐ (Please tick one box only)

11. CONFIDENTIAL MEDICAL HISTORY

A. Principal AA. Spouse/Partner B1. Dependant
B2. Dependant B3. Dependant B4. Dependant

		A		AA		B1		B2		B3		B4	
	QUESTIONS	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
A	Do you smoke?												
B	Has any person named in this form been admitted to a hospital or nursing home or had any medical tests done in the last 2 years?												
C	Has any specialist been consulted and/or provided prescriptions for any drugs or medication in the last1years?												
D	Has any application for life, accident, health or any other insurance been refused or had special terms applied?												
E	Does any person named in this form anticipate the need or has been recommended to undergo any medical tests or investigations in the foreseeable future?												
F	Has any person named in this form ever suffered from or are suffering from any disease or condition stated below?												

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12. MEDICAL CONDITION

S/N	MEDICAL CONDITION	YES	NO
1	High Blood pressure or circulatory disorders		
2	Stroke or Paralysis		
3	Heart diseases		
4	Fainting, blackout, dizziness, seizures, fits, etc		
5	Stomach ulcer, hepatitis, gall bladder disease, intestinal or bowel disorders		
6	Asthma, persistent cough, breathlessness or other respiratory disorders		
7	Kidney, Bladder, Prostrate or Genito-Urinary disorders		
8	Gynecological or hormone disorders		
9	Diabetes, High Cholesterol or other blood disorders		
10	Tumour, growth, cancer or glandular diseases or abnormalities		
11	Diseases or disorders of the eyes, ears, nose and throat		
12	Mosculo-skelatal disorders		
13	Mental disorders		
14	Any diseases, disorders or conditions which are long lasting or recurrent		
15	Management for drug or substance abuse		
16	Any other illnesses, disabilities or defects that have not been mentioned above		

if your answer to Question 16 above is YES, please provide details below:

_____

_____

10. DECLARATION

I hereby declared that the information given in this form is complete and true. I am aware that if I give any false or misleading information deliberately, my enrollment may be rejected, or may be terminated back to the date of this application. I am also aware that if I leave out important information in this form, my enrollment may be rejected. I am also aware that I must give true and complete information on my dependent(s) (spouse and children) otherwise, their enrollment may be rejected or terminated back to the date of this application.

I understand and agree that any disputes between myself (including any of my enrolled family members) and AIHS must be submitted to final and binding arbitration. I also understand that disputes that I may have with Songhai Health Trust involving claims for medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) are also subject to final and binding arbitration.

My signature below indicates that I understand and agree with the terms of this Agreement.

_____ _____

DATE SIGNATURE OF APPLICANT DATE