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/Staff ID: _____

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: _____

NIN _____

Phone: _____ E- Mail: _____

PASSPORT

Name & Number of Next of Kin: _____

Preferred Hospital: _____

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

_____

Alternative Hospital _____

2. DEPENDANT DETAILS

LAST NAME	FIRST NAME	GENDER	DATE OF BIRTH	NIN	RELATIONSHIP	PRE-EXISTING CONDITION	PHONE NO

SPOUSE PASSPORT

DEPENDANT 1 PASSPORT

DEPENDANT 2 PASSPORT

DEPENDANT 3 PASSPORT

DEPENDANT 4 PASSPORT

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

TOPAZ ☐ SAPHIRE ☐ EMERALD ☐ RUBY ☐ DIAMOND ☐

COMMENCEMENT DATE: | dd | mm | yyyy |

(Date you want cover to commence)

4. MEDICAL CONDITION

Do you or any of your family member suffer from any of the following condition? Please tick from the boxes which one applies to your family and indicate against the person's name above.

Tuberculosis ☐	Hypertension ☐	Diabetes ☐	Epilepsy ☐	Asthma ☐	Peptic ulcer ☐	Heart disease ☐
Glaucoma ☐	Kidney disease	Arthritis ☐	HIV Aids ☐	Sickle cell ☐	Pregnancy ☐	others ☐

5. 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 Ashmed Integrated Health Services 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.

_____ _____

SIGNATURE OF APPLICANT DATE

DATE

FOR OFFICIAL USE

ENROLEMENT OFFICER DETAIL

NAME_____

LOCATION_____

SIGN:_____DATE:_____