

## **IMO STATE HEALTH INSURANCE AGENCY**

Address: Quinters Youth Avenue, Opposite Civic Centre, Off Concord Road Owerri Email: info@imshiaonline.com | Tel: 08139322999

## **ENROLMENT FORM**

Principal (Staff) Member Passport

Passport							
MDA's Name (Pay Point)		Staff ID/ Number:					
Enrollee Name: Surname:		First Name:					
Date of Birth (DD/MM/YYYY)	Region:	Marita <mark>l Status:</mark>	Sex:				
State of Origin:	LGA::	T <mark>own Nam</mark> e:					
Job Title	Mobile No. (1)	(2)					
Residential Address:		2					
Email:	Genotype & Blood Group:						
Choice of Hospital:	PURAT						
State any Pre-Existing Medical (Diabetes, Hypertension. Sickl	Condition e Cell, Cancer. Kidney Iss	ue, Others) This is for EXP	ERT MANAGEMENT				
	DECLARA	ATION					
I,are true, that I have not concealed to access my eligibility for health in Are there any additional facts affermade aware of? Yes No	d nor withheld anything with nsurance.  cting the risk of assurance o	n your health of which the <b>AG</b>	cquainted with in othe  ENCY should be				
I agree that these and all statemer connection with this or previous processes the statement of the statemen			xaminer(s) in				
Client Signature :		Date:					



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	Principal Staff Member Passport	Sponsor's Passport	Child 1 Passport	Child 2 Passport	Child 3 Passport	Child 4 Passport				
	: <i>Kindly affix rece</i> ; Kindly affix rece	nt passport nt photographs, follo	owing the sequence	e as stated.						
MOA	MOA's Name (Pay Point):Sta ffID/Number									
Fnro	llers Name: (Su	rname)	Firs	t Name	Othe	er Name:				
						Sex:				
State	e of Origin	I GA·	rtegioni_	Town Name	e.					
Resi	dential Address		10. (1)		101.12					
Ema	il:			Genotype & Blood	Group					
Cho	ice of Hospital:									
Stat	e any Pre-Exis	sting Medical Co	ndition							
(Dia	betes, Hypert	ension. Sickle C	ell, Cancer. Kidı	ney Issue, Other	rs) This is for EX	PERT MANAGEMEN				
		DEF	PENDENTS DE	TAILS						
	SPOUSE			Pre-Existing condition;						
Full 1	Vame			Occupation:						
		/YYYY)	Sex	Telephone No:						
Choi	ce of Hospita	ıl:		OLUI D.						
Pre-E	xisting c <mark>ondi</mark>	tion;	<b>_</b>	CHILD :						
Occupation:			Full Name							
ieiek					D/MM/YYYY)					
	CHILD 1			Pro Existing	condition;					
Full	Name			Occupation:	Jonamon,					
Birth Date (DD/MM/YYYY) Sex Choice of Hospital: Pre-Existing condition;			Occupation: Telephone No:							
				CHILD 4						
	upation:			Full Name						
lele	phone No:				D/MM/YYYY)	Sex				
	CHILD 2			Choice of Ho						
Full	Name	A								
	Date (DD/M/	W/YYYY)	Sex	Occupation: Telephone No:						
Cho	ice of Hospit	al:								
			DECLAR	ATION						
eligibili	ity for health insu	ed nor withheld any rance. I facts aff <u>ect</u> ing the r	thing with which the	assurer should be	acquainted with in					
made	aware of? Yes	□ No□ If Ye	es, State details:							
		all statements I have al(s) shall be the bas		e to the assurer or i	its medil examiner(s	s) in connection with				

\_\_\_\_\_ Date: \_\_

Client Signature :\_\_