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

MDA's Name (Pay Point)____________________ Staff ID/ Number:____________

Enrollee Name: Surname: ____________________ First Name:________________

Date of Birth (DD/MM/YYYY)__________Region:________ Marital Status:________ Sex:_____

State of Origin: ______________ LGA::______________ Town Name:____________

Job Title________________ Mobile No. (1)______________ (2)______________

Residential Address:____

Email: __________________________ Genotype & Blood Group: ______________

Choice of Hospital:____

State any Pre-Existing Medical Condition ____________________________
(Diabetes, Hypertension. Sickle Cell, Cancer. Kidney Issue, Others) This is for EXPERT MANAGEMENT

ENROLMENT FORM

DECLARATION

I,______________________________ the assured, do hereby declare that all that the foregoing answers are true, that I have not concealed nor withheld anything with which the assurer should be acquainted with in other to access my eligibility for health insurance.

Are there any additional facts affecting the risk of assurance on your health of which the **AGENCY** should be made aware of? Yes☐ No☐ If Yes, State details:______________________________

____

I agree that these and all statements I have made or shall make to the assurer or its medil examiner(s) in connection with this or previous proposal(s) shall be the basis of this contract.

Client Signature :______________________________ Date: ________________

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ENROLMENT FORM

Principal Staff Member Passport	Sponsor's Passport	Child 1 Passport	Child 2 Passport	Child 3 Passport	Child 4 Passport

Note: Kindly affix recent passport

Note; Kindly affix recent photographs, following the sequence as stated.

MOA's Name (Pay Point): ______________________________Sta ffID/Number ____________

Enrollers Name: (Surname) ________________ First Name:________________ Other Name:_______

Date of Birth(DD/MM/Year)______________ Region:____________Marital Status:_________ Sex:_______

State of Origin:__________ LGA:______________________ Town Name:_________________________

Job Title:_______________ Mobile No. (1)________________________ Tel: (2)__________________

Residential Address:. ____

Email: ___________________________________Genotype & Blood Group____________________

Choice of Hospital:____

State any Pre-Existing Medical Condition ____

(Diabetes, Hypertension. Sickle Cell, Cancer. Kidney Issue, Others) This is for EXPERT MANAGEMENT

DEPENDENTS DETAILS

SPOUSE

Full Name______________________________
Birth Date (DD/MM/YYYY)_____________Sex___
Choice of Hospital:_______________________
Pre-Existing condition; ___________________
Occupation:_____________________________
Telephone No:___________________________

CHILD 1

Full Name______________________________
Birth Date (DD/MM/YYYY)_____________Sex___
Choice of Hospital:_______________________
Pre-Existing condition; ___________________
Occupation:_____________________________
Telephone No:___________________________

CHILD 2

Full Name______________________________
Birth Date (DD/MM/YYYY)_____________Sex___
Choice of Hospital:_______________________
Pre-Existing condition; ___________________
Occupation:_____________________________
Telephone No:___________________________

CHILD 3

Full Name______________________________
Birth Date (DD/MM/YYYY)_____________Sex___
Choice of Hospital:_______________________
Pre-Existing condition; ___________________
Occupation:_____________________________
Telephone No:___________________________

CHILD 4

Full Name______________________________
Birth Date (DD/MM/YYYY)_____________Sex___
Choice of Hospital:_______________________
Pre-Existing condition; ___________________
Occupation:_____________________________
Telephone No:___________________________

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DECLARATION

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I agree that these and all statements I have made or shall make to the assurer or its medil examiner(s) in connection with this or previous proposal(s) shall be the basis of this contract.

Client Signature :_________________________________ Date: ________________