HCI *Healthcare*

ENROLLEE FORM

PLEASE FILL IN BLOCK LETTERS

Click here to add photo	Click here to add photo	Click here to add photo	Click here to add photo	Click here to add photo	Click here to add photo
Passport Photo	Spouse	Dependant 1	Dependant 2	Dependant 3	Dependant 4

SURNAME | MIDDLE NAME | OTHER NAME

ADDRESS

OCCUPATION | DESIGNATION

PHONE NUMBER (mobile) | (Fixed) | Email Address

PLAN TYPE	
HOSPITAL OF CHOICE	
ALLERGIES	

SEX | DATE OF BIRTH-dd/mm/yyyy | GENOTYPE | BLOOD GROUP

NAME OF EMPLOYER

ADDRESS OF EMPLOYER

SPOUSE

SURNAME | MIDDLE NAME | OTHER NAME

ADDRESS

OCCUPATION | DESIGNATION

PHONE NUMBER (mobile) | (Fixed) | Email Address

SEX | DATE OF BIRTH-dd/mm/yyyy | GENOTYPE | BLOOD GROUP

PLAN TYPE	

HOSPITAL OF CHOICE	
ALLERGIES	

PAST MEDICAL HISTORY

Do you or have you ever suffered from any of the following ailments? If so please indicate.

(a) Hypertension (b) Diabetes Mellitus
(c) Duodenal Uleer (d) Sickle Cell Disease
(e) Glaucoma (f) Heart Disease
(g) Kidney Disease (h) Epilepsy
(i) Asthma (j) Tuberculosis
(k) HIV/AIDS

	CONDITION SUFFERED	WHEN

Have you ever had a surgical operation?

If yes, what type of surgery was it and when?

Please state any other relevant information you would like us to have concerning your health

DEPENDANT 1

SURNAME | MIDDLE NAME | OTHER NAME

SEX | DATE OF BIRTH-dd/mm/yyyy | GENOTYPE | BLOOD GROUP

ALLERGIES

HOSPITAL | RELATIONSHIP

DEPENDANT 2

SURNAME | MIDDLE NAME | OTHER NAME

SEX | DATE OF BIRTH-dd/mm/yyyy | GENOTYPE | BLOOD GROUP

ALLERGIES

HOSPITAL | RELATIONSHIP

DEPENDANT 3

SURNAME | MIDDLE NAME | OTHER NAME

SEX | DATE OF BIRTH-dd/mm/yyyy | GENOTYPE | BLOOD GROUP

ALLERGIES

HOSPITAL | RELATIONSHIP

DEPENDANT 4

SURNAME | MIDDLE NAME | OTHER NAME

SEX | DATE OF BIRTH-dd/mm/yyyy | GENOTYPE | BLOOD GROUP

ALLERGIES

HOSPITAL | RELATIONSHIP

DECLARATION

I hereby declare that all information given above are all true to the best of my knowledge and that I have not concealed or witheld any information. I also agree to abide by the terms and conditions of the Healthcare Scheme.

Click here to add signature

Signature

DATE

HCI HEALTHCARE

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