



HCI Healthcare

ENROLLEE FORM (Individual)

PLEASE FILL IN BLOCK LETTERS

SURNAME: FIRST NAME: OTHER NAMES:

ADDRESS:

CITY: STATE: PHONE NO:

OCCUPATION: DESIGNATION: email:

Date Of Birth: SEX: GENOTYPE: BLOOD GROUP:

EMPLOYER:

EMPLOYER'S ADDRESS:

PLAN TYPE: RELIGION: ALLERGIES:

HOSPITAL OF CHOICE:

PAST MEDICAL HISTORY

Do you or any member of your family suffer (or had suffered) fro any of the following ailment?If so indicate the name and condition(s) appropriately

- | | | |
|---|--|--|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Duodenal Ulcer | <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Kidney Diseas | <input type="checkbox"/> Diabetes Mellitus | |
| | <input type="checkbox"/> Sickle Cell | |

Have you ever had a surgical operation?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?

Waiting Period and limitations

1. There is a waiting period of 14 days after receipt of your duly completed form and photographs before you can visit your hospital of choice.
2. All non-emergency surgeries are subject to pre- authorization.
3. Maternity care: There is a waiting period of One (1) year after plan commencement before you can enjoy access to maternity care.
4. Chronic conditions: These conditions such as hypertension, diabetes mellitus, bronchial asthma, etc, which cause you to be on regular prescribed medication, will only be covered after one year from date of diagnosis, provided that the illness started and was diagnosed while on the scheme.

Terms of Subscription for individual (non-group) plan

Plan Period: One year from commencement date, renewable yearly

Eligibility: 0 - 65 years of age

Exclusions: The following conditions are not covered under the scheme:

- | | |
|---|---|
| a. Medical services not included in selected plan. | h. Chronic renal dialysis |
| b. Pre-existing conditions: any medical condition that existed prior to commencement date such as hypertension, diabetes, asthma etc. | i. major surgeries to head, spinal cord as well as organ transplants. |
| c. Alternative medical treatment, nutritional supplements. | j. Treatment of psychiatric conditions. |
| d. Cosmetic treatments. | k. HIV/AIDS and related conditions. |
| e. Secondary and tertiary dental care. | l. Injuries resulting from Suicide attempts. |
| f. Obesity, infertility, impotence, prosthesis, artificial limbs. | m. Injuries resulting from Domestic violence. |
| g. Cancer and other chronic conditions. | n. Medical treatment from outside the Fedal Republic of Nigeria. |

Declaration

I, hereby declare that all information given above are true to the best of my knowledge and that I have not concealed or withheld any information. I have also read and understood the above and declare that the terms are acceptable to me. I agree that Healthcare International shall not be liable for any claims that arise from conditions or treatments contrary to the above terms. I authorize any medical practitioner or organization having medical information concerning me/us to provide such information to Healthcare International.

Signature:

Date:

Submit by Email

Print Form