

RC: 238431

## FAMILY/INDIVIDUAL ENROLLEE PERSONAL DATA FORM (FEPDF04)

(PLEASE TURN OVER FOR INSTRUCTIONS BEFORE COMPLETING THIS FORM)

**PART 1**

**POLICY COVER** (Please tick)    **Bronze**     **Silver**     **Gold**

**NAME** Mr./Mrs./Ms.           

**DATE OF BIRTH**          **GENDER**       

**RESIDENTIAL ADDRESS** (Please include P.O. Box)

**TELEPHONE NO. 1**     **TELEPHONE NO. 2**

**E-MAIL ADDRESS**

**CHOICE OF HOSPITAL**   

**CHRONIC/PRE-EXISTING CONDITION**  
(Please refer to back for list of pre-existing conditions)

**ARE YOU OR ANY OF YOUR DEPENDANTS PREGNANT?**       

**PART 2** (This part refers to your spouse and dependants only, if applicable)

**NAME OF SPOUSE**            **DATE OF BIRTH**   

**CHOICE OF PRIMARY HOSPITAL**   

**CHRONIC/PRE-EXISTING CONDITION**

	Names of Children	Date of Birth	Sex	Choice and Location of hospital	Pre-existing conditions
1		DD/MM/YYYY	M/F		
2		DD/MM/YYYY	M/F		
3		DD/MM/YYYY	M/F		
4		DD/MM/YYYY	M/F		

**CHILD 1**

Affix photograph here.

**CHILD 2**

Affix photograph here.

**CHILD 3**

Affix photograph here.

**CHILD 4**

Affix photograph here.

Declaration: I hereby apply to be enrolled in the plan together with the persons to be insured listed above. I declare that to the best of my knowledge on behalf of all persons to be insured under this application that I have read and understand fully the policy exclusions and conditions. It is agreed that this declaration and information given in this application shall form the basis of the contract(s) between the insured person(s) and the HMO.

Any false information provided in respect of the medical profile of the insured invalidates the policy.

Signature of Principal Enrollee \_\_\_\_\_ Date \_\_\_\_\_  
On behalf of all beneficiaries

FOR OFFICIAL USE ONLY (Please leave blank)	CL/ / / /
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## HOW TO FILL THIS FORM

1. **This form must be filled in CAPITAL LETTERS Only Using BLACK INK.**
2. **Please write only one letter or number, DO NOT ADJOIN YOUR LETTERS OR NUMBER e.g. J O S E P H**
3. **Policy cover;** the type of cover you are entitled to, is dependent on the premium you have paid.  
**Premium Rating;** *Depending on choice of hospital (please visit our website [www.clearlinehmo.net](http://www.clearlinehmo.net))*  
**Bronze Policy** ----- **N50.00** per day ----- **N1,500** per month ----- **N18,000** per annum  
**Silver Policy** ----- **N173.61** per day ----- **N2,083.30** per month ----- **N25,000** per annum  
**Gold Policy** ----- **N208.33** per day ----- **N 6,250** per month ----- **N75,000** per annum  
If you are unsure of the cover you are entitled to please contact us through the number on the front of this form.
4. **Principal Enrollee;** this refers to the person applying for the policy. Clearly state your surname, first name in full and middle initials, if any.
5. **Date of birth;** clearly state your date of birth, as this ensures a proper update of your medical records on our database.
6. **Sex;** tick the box applicable to you.
7. **Residential address;** please put your current house number, street name, area and state. This will be printed on your I.D card and also serves as a direct mail correspondence to deliver documentations to you.
8. **Email address;** please state your full email address. This serves as an alternate means of contacting you and also to advise you on your current status and to update you with information regarding any new products or developments regarding our services.
9. **Personal telephone number;** provide your current telephone number to enable us contact you in case of emergency or other matters.
10. **Choice of hospital;** write the name and state in which the hospital is located.
11. **Chronic/pre-existing condition;** find below a list of what we refer to as a recurring chronic/pre-existing conditions

Arthritis	Herpes Genitalis	Persistent chest pain
Asthma	HIV/AIDS	Sickle Cell Disease
Cancer	Hypertension	Skin Infection
Cataract	Hemorrhoids	STD's
Diabetes Mellitus	Heart Disease	Tuberculosis
Epilepsy	Hepatitis	Ulcers
12. **Photographs;** please affix a current passport-sized photograph of yourself and each of your dependants in the boxes indicated. i. Ensure photographs are taken with blue or red background. ii. Ensure photographs are of current likeness of each individual. iii. Please write the names of each person on the back of their passport photographs

## TERMS AND CONDITIONS

1. This form is a **LEGAL** document.
2. This form is a contract between the principal enrollee and Clearline International Limited and is subject to the length of validity of your policy
3. A 100% payment must be paid before the policy will be activated.
4. Any false information provided in respect of your past medical history invalidates the policy.
5. Please choose **only** one hospital and **not more** than four different hospitals for your spouse and dependants (if any).
6. This form must be delivered to our office by the 17<sup>th</sup> day of every month.
7. If the service received from a chosen hospital is unsatisfactory, please complete form **CHC02** and send it to our office by the 17<sup>th</sup> day of that month.
8. If you wish to include additional dependants, please complete form **SDICL03** and send it to our office by the 17<sup>th</sup> day of that month.
9. Failure to receive any of these forms (**EPDF, CHC02, and SDICL03**) will result in a 30day delay in the processing of enrollee requests.
10. Clearline International Limited will not responsible for the delay in activating the policies of enrollees who submit inaccurate and/or incomplete **EPD, CHC02, SDICL03** forms received on the 17<sup>th</sup> day of every month.