GREEN FIELD HEALTH MANAGEMENT LIMITED

(Health Maintenance Organization)

SPOUSE/DEPENDANT INCLUSION FORM

INSTRUCTION: (I) USE Biro Only. (II) Write in Block (Capital) Letters. (III) Any Information Not Available NOW, Write "N/A"

Personal Data:

Employer's Name ______ GFHML IDENTIFICATION NUMBER ______

Mr. /Mrs. /Ms. Surname ______ First Name ______ Middle Name ______

E-mail Address ______

Telephone Number(s) ______ ______ Residential Address (Not P.O. Box or P.M.B) ______

* Please specify the spouse or dependants to be included in this section

	First Name & Middle Name	Date of Birth	Sex	Blood Group	Hb Genotype	Pre-existing condition
Spouse						Yes/No
Child 1						Yes/No
Child 2						Yes/No
Child 3						Yes/No
Child 4						Yes/No

* **Choice of Hospital**: Same as Principal ☐ , Other (Please Specify) ______

State of Location ______

* Pre-existing condition (If **Yes**) specify ______

SPOUSE AFFIX PHOTOGRAPH	CHILD 1 AFFIX PHOTOGRAPH	CHILD 2 AFFIX PHOTOGRAPH	CHILD 3 AFFIX PHOTOGRAPH	CHILD 4 AFFIX PHOTOGRAPH

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 completely 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.

Principal Enrollees' Signature (*on behalf of all beneficiaries*)............................ Date...................................