DATE:_____/_____/_____

PIX
OF
PRINCIPAL (P)

SUBSCRIPTION FORM

New Membership ☐ Additional Membership ☐ *(Please mark the appropriate box)*

Please complete in BLOCK LETTERS and attach all the members' passport photograph

A.PERSONAL DATA OF PRINCIPAL MEMBER (P)

Surname ***Other Names*** *(please leave at least an empty box in between names)*

Gender: M F ***Date of Birth (DDMMYYYY)*** ***Marital Status***

Residential Address					
Cell Phone No.		Office Phone No.			
State of Origin		Nationality		e-mail:	
Local Govt.		Town/City		Staff ID/ No.	
Company Name & Address					
Designation/position				Location in the Organization	

B. DETAILS OF NEXT OF KIN

Name: *(Surname First)*				☎:	
Address:					
M		F		Town/City:	e-mail:

C. DETAILS OF DEPENDANTS: *(please inscribe names at the back of each passport photograph)*

Pix of Spouse(s)	Pix of 1st **Dependant**	Pix of 2nd **Dependant**	Pix of 3rd **Dependant**	Pix of 4th **Dependant**
FULL NAMES	FULL NAMES	FULL NAMES	FULL NAMES	FULL NAMES
GENDER	GENDER	GENDER	GENDER	GENDER
___/___/___ ***DATE OF BIRTH***	___/___/___ ***DATE OF BIRTH***	___/ ___/___ ***DATE OF BIRTH***	___/_____/___ ***DATE OF BIRTH***	___/____/___ ***DATE OF BIRTH***

D. PROVIDER OF CHOICE ***(***Please do not fill more than 1 column if principal and dependants have the same provider)***

Status	***Name of Member***	***Primary Provider of Choice***	***Provider Code(if any)***
P			
S			
1st			
2nd			
3rd			
4th			

E .MEDICAL RECORDS

Kindly answer the following questions for the purpose of quality assurance (mark √ and give details if appropriate):

Questions	**Yes**	**No**	If yes give Details
Are you currently on any Drug or Medication?			
Have you been Hospitalized before?			
Do you have any History of Allergy?			
Are you pregnant? If yes what is the EDD?			
Do you or any of your dependants have any Pre-existing Medical Condition?			

F.DECLARATION

- I declare that any false statement above or non-disclosure of any material fact will render the subscription null and void.
- I understand that my membership will be accepted on payment of the subscription fee.
- I hereby give permission to Roding Healthcare to have access to any of my medical records.
- I hereby accept the terms and conditions of subscription to the Roding Healthcare Benefit package

Signature of principal _____ **Date** _____/_____/_____

* ***Please attach a duplicate copy of your international passport/Driver's License/National ID card.***

If the applicant is under 18 years of age this declaration must be signed by their parent or legal guardian.

FOR OFFICE USE ONLY

ROHL ID Number:	Health plan:	PAKAGE ID:
Annual Limits:	Account Number:	Subscription Payment Modality: