



HEALTHCARE SECURITY LIMITED

REGISTRATION FORM

In collaboration with National Health Insurance Scheme

Principal
Use gum only to
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Passport
Photograph
3cmx3.5cm

1. PERSONAL DATA:

Name																			
E-Mail										Date Of Birth					Marital Status				
State of posting										Phone No. (GSM)					Age		Sex		

2. Employer's Data:

Name																			
Location/Address																			

3. Preferred Health Care Facility (HOSPITAL):

Name of Facility (HOSPITAL)																			
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4. Alternative Health Care Facility (HOSPITAL):

Name of facility (HOSPITAL)																			
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NOTE: Alternative health care facility must only be selected for dependents that are in a different location

5. Healthcare Plans:

Select any of the healthcare plan you will like to undertake

Budget Budget Plus Standard Executive

6. Medical History of Significance:

A. Diabetes B. Epilepsy C. Hypertension D. Sickle Cell Disease E. Allergies F. Asthma

7. Dependants: One (1) Spouse and Four (4) Biological Children

Spouse

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Name I. Spouse									
Sex		Date of Birth							
A	B	C	D	E	F				

Child 3

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Name IV. Child 3									
Sex		Date of Birth							
A	B	C	D	E	F				

Child 1

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Name II. Child 1									
Sex		Date of Birth							
A	B	C	D	E	F				

Child 4

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Name V. Child 4									
Sex		Date of Birth							
A	B	C	D	E	F				

Child 2

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Name III. Child 2									
Sex		Date of Birth							
A	B	C	D	E	F				

Alternate Health Care Facility
PLEASE TICK THE BOX BELOW IF USING ALTERNATE HEALTHCARE FACILITY

Spouse	Child 1	Child 2	Child 3	Child 4
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_____ Date

_____ Signature