MetroMini HEALTH INSURANCE REGISTRATION FORM

MetroHealth HMO Limited

GROUP / COMPANY NAME	DIVISION	EFFECTIVE DATE	CONTRACT / ID NUMBER (official use)

EMPLOYEE/PRINCIPAL NAME

FIRST **MIDDLE** **LAST**

ADDRESS

STREET

CITY *STATE* LOCATION

TELEPHONE (GSM) ( )

TELEPHONE (WORK) ( )

MARITAL STATUS

☐ *MARRIED* ☐ *SINGLE* ☐ *DIVORCED*

TYPE OF COVERAGE

☐ *INDIVIDUAL* ☐ *INDIVIDUAL & SPOUSE* ☐ *FAMILY*

IT IS VERY IMPORTANT THAT EACH MEMBER SELECTS A PRIMARY CARE PHYSICIAN.
ALL MEDICAL AND HEALTH CARE NEEDS MUST BE PROVIDED OR ARRANGED BY THE PRIMARY CARE PHYSICIAN.

FIRST MI LAST (IF NOT SAME AS EMPLOYEE)	DATE OF BIRTH DAY MO YR	SEX (M/F)	GSM NUMBER	EMAIL ADDRESS	SELECT A PRIMARY CARE PHYSICIAN FOR EACH MEMBER
EMPLOYEE/PRINCIPAL FIRST MI LAST	- -				
SPOUSE FIRST MI LAST	- -				
DEPENDENT FIRST MI LAST	- -				
DEPENDENT FIRST MI LAST	- -				
DEPENDENT FIRST MI LAST	- -				
DEPENDENT FIRST MI LAST	- -				

To produce the Health Insurance ID card, please capture the finger print of the right thumb of each person to be covered in the boxes below and staple the passport picture on top of the box. The thumb should be covered with blue or black ink to ensure that a clear finger print is obtained for each individual.

I have read through the registration handbook and understand the benefit plan. I also acknowledge that by completing and signing my registration form for the metro health plan, I have given consent for Metro Health HMO to request or inspect medical and other records maintained by my selected hospital for case management and complaint resolution purposes and no further written request will be necessary for the release of medical information to Metro Health HMO.

ENROLLEE SIGNATURE & DATE

METRO HEALTH HMO AUTHORISED SIGNATURE & DATE

Corporate Office: 14th Floor, St. Nicholas House, 26 Catholic Mission Street, Lagos, **Call Centre**: +(234) 1 460 6790 **E**: info@metrohealthhmo.com **W**: www.metrohealthhmo.com