Clearline International Limited HMO
RC: 238431

16A Oyefeso Avenue, Savoil Bus-Stop, Obanikoro, Lagos
Website: www.clearlinehmo.com E-mail: info@clearlinehmo.net

24-HR CALL CENTRE NOS
01-7408573, 07098141894

CORPORATE ENROLLEE PERSONAL DATA FORM (EPDF01)

(PLEASE TURN OVER FOR INSTRUCTIONS BEFORE COMPLETING THIS FORM)

PART 1

COMPANY NAME

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

NAME *Mr./Mrs./Ms.* *Surname* *First name* *Middle Initials*

DATE OF BIRTH DD MM YYYY ***GENDER*** M F

APPLICANT
Affix
Photograph here.

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

TELEPHONE NO ***E-MAIL***

CHOICE OF HOSPITAL *Hospital name, location*

DO YOU HAVE ANY CHRONIC/PRE-EXISTING CONDITIONS **YES** **NO**

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

ARE YOU OR ANY OF YOUR DEPENDANTS PREGNANT? **YES** **NO**

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

NAME OF SPOUSE *First name* *Initials* ***DATE OF BIRTH*** DD MM YYYY

Spouse
Affix
Photograph here.

CHOICE OF PRIMARY HOSPITAL *Hospital name. Location*

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
On behalf of all beneficiaries _____ **Date** _____

FOR OFFICIAL USE ONLY (Please leave blank)	**CL/ / / /**

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. **Company Name**; if you are applying under your employer please indicate the name of your employer (company)
4. **Policy cover**; the type of cover you are entitled to, is dependent on the premium you have paid. If you are unsure of the cover you are entitled to please contact us through the number on the front of this form.
5. **Principal Enrollee**; this refers to the person applying for the policy. Clearly state your surname, first name in full and middle initials, if any.
6. **Date of birth**; clearly state your date of birth, as this ensures a proper update of your medical records on our database.
7. **Sex**; tick the box applicable to you.
8. **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.
9. **Email address**; please state your full email address. This serves as an alternate means of contacting you and also to advice you on your current status and to update you with information regarding any new products or developments regarding our services.
10. **Personal telephone number**; provide your current telephone number to enable us contact you in case of emergency or other matters.
11. **Choice of hospital**; write the name and state in which the hospital is located.
12. **Chronic/pre-existing condition;** find below examples of what we refer to as a recurring chronic/pre-existing conditions

Arthritis	Herpes Genitalis	Pregnancy (prior to commencement of policy)
Asthma	HIV/AIDS	
Cancer	Hypertension	
Cataract	Persistent chest pain	
Diabetes Mellitus	Sickle Cell Disease	
Epilepsy	Skin Infection	
Heart Disease	STD's	
Hemorrhoids	Tuberculosis	
Hepatitis	Ulcers and other chronic/pre-existing conditions	

13. **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 backgrounds. 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, unless previous agreements have been reached.
4. Any false information provided in respect of your past medical history invalidates the policy and your premium will not be refunded.
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 17th 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 17th day of that month.
8. If you wish to include additional dependants, please complete form **SDICL03** and send it to our office by the 17th 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 17th day of every month.