Clearline International Limited HMO
RC: 238431

16A Oyefeso Avenue, Savoil Bus-Stop, Obanikoro, Lagos

01-7617433, 01-7741092

Website: www.clearlinehmo.com E-mail: info@clearlinehmo.net

SPOUSE/DEPENDANT INCLUSION FORM (SDICL03)

PLEASE REFER TO BACK BEFORE COMPLETING THIS FORM

PART 1

COMPANY NAME, *If applicable*

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

CLEARLINE IDENTIFICATION NUMBER

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

TELEPHONE NO. 1 **TELEPHONE NO. 2**

E-MAIL

PART 2

This part is for the spouse and dependants being included

NAMES	*Date of Birth*	*CHOSEN HOSPITAL*	*RELATIONSHIP*	*PRE-EXISTING CONDITIONS*
Spouse	DD/MM/YYYY			
Child 1	DD/MM/YYYY			
Child 2	DD/MM/YYYY			
Child 3	DD/MM/YYYY			
Child 4	DD/MM/YYYY			

SPOUSE	**CHILD 1**	**CHILD 2**	**CHILD 3**	**CHILD 4**
Affix photograph here.	Affix photograph here.	Affix photograph here.	Affix photograph here.	Affix photograph here.

Declaration: I hereby apply to enroll the following person(s) listed above to be insured under my policy. 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
4. **Principal Enrollee**; this refers to the person applying for the policy. Clearly state your surname, first name in full and middle initials, if any.
5. **Clearline Identification number**; this is your unique number stated clearly on your health insurance Identification card e.g. CL/AAA/001/02B/G
6. **Personal telephone number**; provide your current telephone number to enable us contact you in case of emergency or other matters.
7. **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.
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. **Choice of hospital**; write the name and state in which the hospital is located.
10. **Chronic/pre-existing condition;** find below a list of what we refer to as a recurring chronic/pre-existing conditions

Arthritis	Herpes Genitalis
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

11. **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 background. 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 registered and is subject to the length of validity of your policy
3. Any false information provided in respect of your past medical history invalidates the policy.
4. Please choose **only** one hospital and **not more** than four different hospitals for your spouse and dependants (if any).
5. This form must be delivered to our office by the 17th day of every month.
6. 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.
7. If you wish to include additional dependants, please complete form **SDICL03** and send it to our office by the 17th day of that month.
8. Failure to receive any of these forms (**EPDF, CHC02, and SDICL03**) will result in a 30day delay in the processing of enrollee requests.
9. 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.