PIX
OF
PRINCIPAL (P)

RODING HEALTHCARE LTD

DATE:_____/______/_______

# SUBSCRIPTION FORM FOR RETIREES/PENSIONERS/ELDERLY/SPECIAL ALUMNI

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 SPOUSE {S} (if applicable ): *( please inscribe names at the back of each passport photograph)*

**Pix of Spouse**

_______________
FULL NAMES

_______________
GENDER

____/_____/_____
***DATE OF BIRTH***

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

| ***Status*** | ***Name of Member*** | ***Primary Provider of Choice*** | ***Provider Code(if any)*** |
|---|---|---|---|
| ***P*** | | | |
| ***S*** | | | |

**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 or your spouse currently on any Drug or Medication? | | | |
| Have you or your spouse been Hospitalized before? | | | |
| Do you or your spouse have any History of Allergy? | | | |
| Are you or your spouse pregnant? If yes what is the EDD? | | | |
| Do you or your spouse 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.***

**FOR OFFICE USE ONLY**

| ROHL ID Number: | Health plan: | PACKAGE ID: |
|---|---|---|
| Annual Limits: | Account Number: | Subscription Payment Modality: |

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