REGISTRATION FORM

HYGEIA HMO

PRINCIPAL	SPOUSE	CHILD 1	CHILD 2	CHILD 3	CHILD 4
Place a passport photograph here and print name on the reverse side	*Place a passport photograph here and print name on the reverse side*	*Place a passport photograph here and print name on the reverse side*	*Place a passport photograph here and print name on the reverse side*	*Place a passport photograph here and print name on the reverse side*	*Place a passport photograph here and print name on the reverse side*

Company Name: _____ Division (if any): _____

Alternate/Staff ID: _____

Plan type *(Please tick appropriate box below)*

☐ HyDeal ☐ HyLite ☐ HyBrid ☐ HyValue ☐ HyEnhanced ☐ HyLeague ☐ HyLeague Plus

Cover type *(Please tick below as appropriate)*

☐ **Staff** ☐ **Staff & Spouse** ☐ **Staff, Spouse & Dependant**

Principal Details: KINDLY FILL INFORMATION IN BLOCK LETTERS

Surname _____

First Name _____

Other Name _____

Date of Birth _____ *(dd/mm/yyyy)*

Marital Status _____ Gender: _____ *(M/F)*

Mobile _____

Email _____

Residential Address _____

Spouse Details:

Surname _____

First Name _____

Other Name _____

Date of Birth _____ *(dd/mm/yyyy)*

Marital Status _____ **Gender:** _____ *(M/F)*

Mobile _____

Email _____

Residential Address _____

Dependant Details 1:

Surname _____

First Name _____

Other Name _____

Date of Birth _____ **Gender:** _____ *(M/F)*

Dependant Details 2:

Surname _____

First Name _____

Other Name _____

Date of Birth _____ **Gender:** _____ *(M/F)*

Dependant Details 3:

Surname _____

First Name _____

Other Name _____

Date of Birth _____ Gender: _____ *(dd/mm/yyyy)* *(M/F)*

Dependant Details 4:

Surname _____

First Name _____

Other Name _____

Date of Birth _____ **Gender:** _____ *(dd/mm/yyyy)* *(M/F)*

Preferred Hospital

*Hygeia HMO shall be at liberty to review, change and amend the list of its network providers/hospitals (including an Enrollee's preferred hospital) from time to time without prior recourse to the Enrollee. Should this occur, Enrollees will be contacted to opt for another preferred hospital.

DATA SUBJECT PRIVACY/ CONSENT STATEMENT

We, being the principal enrollee/Authorized representative/ Guardian hereby confirm that we have the legal capacity to give consent and hereby voluntarily grant our consent to Hygeia HMO Limited (Hygeia) and its duly appointed representatives, authority to access, retrieve, process, store, transfer as well as use for any legitimate and lawful purpose, our personal and/or medical information including all relevant data envisaged by the extant law including but not limited to the Nigerian Data Protection Regulation (and any amendment thereto) as well as the Nigerian Data Protection Act (and any amendment thereto) solely for the purpose of carrying out their duties and responsibilities as our health insurance Company and providing health maintenance services. We are aware that our information may be shared with third-party service providers of Hygeia HMO for these purposes, and Hygeia HMO shall take measures to protect the said information. We confirm that we are aware of our rights, labilities, and method to withdraw our consent herein at any time by notifying Hygeia HMO in writing and accordingly request that this consent remain in full force and subsist until such a time as when we withdraw same.

In addition, where applicable, I, The principal enrollee confirm that I am the duly authorized representative of my minor children, wards, aged parents and any legal Dependents and accordingly, I hereby grant same consent to Hygeia HMO on behalf of all my dependant(s) who are minors and accordingly request that this consent remain in full force and subsist until such a time as when I withdraw same or such a time when my minor dependant each personally withdraws same after attaining the statutory age of majority

Principal Enrolle's Signature & Date: _____ HR Representative's Signature & Date: _____