



FAMILY ENROLLMENT FORM

Principal Member Passport	Spouse s Passport	Child 1 Passport	Child 2 Passport	Child 3 Passport	Child 4 Passport
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**NOTE:** kindly affix recent photographs, following sequence as stated.

Company Name: TecHopper

Staff ID/Number: techicover@gmail.com

Enrollee Name: Surname afdsdfdsf

First Name: dsfsdfdsf

Other Name: dsfsdfdsfs

Birth Date (DD/MM/YYYY): 11/11/1998, 12:00:00 AM

Religion: fdsfsdfdsf

Marital Status: dsfsdfdsf

Sex: M

Job Title: TecHopper

Mobile No: (1) 3133794390

(2) 3133794390

Residential Address: 333 Fremont Street

Email: user@test.com

Health Plan type: \_\_\_\_\_

Genotype & Blood Group: xcvxcvxcv

Choice of Hospital: vxcvxcvxcv

State any Pre-Existing Medical Condition (Diabetics, Hypertension, Sickle cell, Cancer, Kidney Issue, Other&) :

xcvxcvxcvxc

DECLARATION

I, **afdsdfdsf dsfsdfdsf dsfsdfdsfs** the assured, do hereby declare

that all the foregoing answers are true, that I have not concealed nor withheld anything with which the assurer should be acquainted

with in order to assess my eligibility for health insurance. Are there any additional facts affecting the risk of assurance

on your health of which the company should be made aware? Yes\_\_\_\_\_ No \_\_\_\_\_ If Yes, State details: \_\_\_\_\_

I agree that these and all statements I have made or shall make to the assurer or to its medical examiner(s) in connection with this or previous proposal(s) shall be the basis of this contract.

Client Signature \_\_\_\_\_

Date: 8/14/2020, 12:57:53 PM

ROTHAUGE HEALTHCARE LIMITED