Clear line
International Limited
RC:238431

CLEARLINE HOUSE
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www.clearlinehmo.net

24HOURS CALL CENTER:
01- 4482520, 08071010840,
08076490101,08076490111

ENROLLEE PERSONAL DATA FORM (EPDF01)

PLEASE READ INSTRUCTION AT THE BACK BEFORE COMPLETING THIS FORM

PART 1

Staff ID: LS247/2023/090

COMPANY NAME, LIVESTOCK247.COM

POLICY COVER (Please tick) Bronze [ ] Silver [ ] Gold [ ] Gold plus [ ] Platinum [ ]

NAME Mr. / Mrs./Ms. LAWRENCE (Surname) | | (First name) | JOHN (Middle name)

DATE OF BIRTH 06 (DD) 06 (MM) 1989 (YYYY) GENDER [M] [F]

RESIDENTIAL ADDRESS PLOT 765 A/B DOMA 2 EXTENSION HAJJ CAMP GWAGWALADA ABUJA

TELEPHONE NO. (1) 08109076869 E-MAIL JOHN.LAWRENCE@LIVESTOCK247.COM

(2) CHOICE OF HOSPITAL: JERAB HOSPITAL HOSPITAL LOCATION GWAGWALADA

CHRONIC/PRE-EXISTING CONDITION (Please refer to back for list pre-existing conditions) NONE

ARE YOU OR ANY OF YOUR DEPENDANTS PREGNANT? YES [X] NO [ ]

Passport Photograph Of Dependant 1

Passport Photograph Of Dependant 2

Passport Photograph Of Dependant 3

Passport Photograph Of Dependant 4

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

NAME OF SPOUSE: Surname UWADIONE | Other Names FAITH | Date of Birth (DD/MM/YYYY) 14/02/1991

EMAIL FAITH8UWADIONE@GMAIL.COM PHONE NO. 08162313158

CHOICE AND LOCATION OF PRIMARY HOSPITAL Hospital name JERAB HOSPITAL

RECURRING /CHRONIC/ PRE-EXISTING-CONDITION PREGNANT

	Dependants Name Surname Other Names	Date of Birth DD/MM/YYYY	Gender M/F	Choice of Hospital / Location	Pre-existing Conditions
1					
2					
3					
4					
5					

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 arid 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. I have read and thereby agree to the terms and conditions on this form

Any false information provided in respect of the medical profile of the insured invalidates the policy, Making your premium Non- refundable

Signature of Principal Enrollee On behalf of all beneficiaries _____ **Date** 10/04/2025

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

HOW TO FILL THIS FORM

1. **This form must be filled in CAPITAL LETTERS Only**
2. Please write only one letter or number at a time. DO NOT ADJOIN YOUR LETTERS OR NUMBER e.g. JOSEPH
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 cover you are entitled to please contact your HR/Admin Dept or contact us
5. **Principal Enrollee:** this refers to the person applying for the policy. Clearly state your surname, first name in full and middle name.
6. **Date of birth**: clearly state your date of birth, as this ensures a proper update of your medical records on our database.
7. **Gender**: tick the box applicable to you.
8. **Residential address**: please put your current house number, street name, area and state.(no longer relevant)
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 numbers to enable us contact you in case of emergency or other matters.
11. **Choice of hospital:** write the name and location in which the hospital is located.
12. **Chronic/pre-existing condition: Please indicate any diseases / illnesses / medical conditions you currently have or have had in the column provided**
13. **Photographs:** please affix a current passport-sized photograph of yourself and each dependants, if any 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 be 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.