DEPENDANT(S) INCLUSION FORM

Main member name (Surname, Other name) Main Member Card Enrollee Number

Additional Enrollee name 1 (Surname, Other name) - Spouse **Sex**

Birth Date Choice of Hospital M F

Day Month Year

Additional Enrollee name 1 (Surname, Other name) - Child 1 **Sex**

Birth Date Choice of Hospital M F

Day Month Year

Additional Enrollee name 1 (Surname, Other name) - Child 2 **Sex**

Birth Date Choice of Hospital M F

Day Month Year

Additional Enrollee name 1 (Surname, Other name) - Child 3 **Sex**

Birth Date Choice of Hospital M F

Day Month Year

Additional Enrollee name 1 (Surname, Other name) - Child 4 **Sex**

Birth Date Choice of Hospital M F

Day Month Year

State any Pre-Existing Medical Condition (Diabetes, hypertension, Sickle cell, Cancer, Kidney Issue, others….) _____

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: …….

DECLARATION

I,……. 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.

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 _____

Spouse's Passport	Child 1 Passport	Child 2 Passport	Child 3 Passport	Child 4 Passport