Member Enrollment Form

AVON HMO

COMPANY NAME:

PLAN TYPE (Please tick the appropriate box)

PRESTIGE PREMIUM PLUS

COVER TYPE (Please tick the appropriate box)

Self only Self & spouse Self, spouse & dependents

STAFF DETAILS

Staff ID No: ______ Surname: ______

First name: ______ Other name: ______

Date of birth: ______ Sex: ______ Marital status: ______

Hospital name and address: ______

Office address: ______

Local Govt Area: ______ Town: ______ State: ______

Home address: ______ Town/State: ______

Local Govt Area: ______ Telephone: ______ Email: ______

Designated next of kin: ______

Address and Telephone: ______

SPOUSE DETAILS

Surname: ______ First name: ______

Other name: ______ Date of birth: ______ Sex: ______

Hospital name and address: ______

Home address: ______

Local Govt Area: ______ Town: ______ State: ______

Telephone: ______ Email: ______

DEPENDENT DETAILS

Surname: ______ First name: ______

Other name: ______ Date of birth: ______ Sex: ______

Hospital name and address: ______

Resident address : ______
(indicate principal/spouse address)

DEPENDENT DETAILS

Surname: ______ First name: ______

Other name: ______ Date of birth: ______ Sex: ______

Hospital name and address: ______

Resident address : ______
(indicate principal/spouse address)

DEPENDENT DETAILS

Surname: ______ First name: ______

Other name: ______ Date of birth: ______ Sex: ______

Hospital name and address: ______

Resident address : ______
(indicate principal/spouse address)

DEPENDENT DETAILS

Surname: ______ First name: ______

Other name: ______ Date of birth: ______ Sex: ______

Hospital name and address: ______

Resident address : ______
(indicate principal/spouse address)