EDO STATE HEALTH INSURANCE COMMISSION

6th & 8th Floor, Block C, Secretariat Buildings

Sapele Road, Benin City

ENROLLMENT FORM

PLEASE FILL ALL FIELDS WITH CAPITAL LETTERS

OFFICE INFORMATION

NAME OF MDA: ....

OFFICE ADDRESS: ....LGA..

DATE OF REGISTRATION: ....

PERSONAL INFORMATION

FIRST NAME: ....MIDDLE NAME: ....

SURNAME: .... MARITAL STATUS..

GENDER: .... DATE OF BIRTH: _ _ /_ _ /_ _ _ _ (DAY / MONTH / YEAR)

RELIGION: .... OCCUPATION: ....

ORACLE NUMBER..NIN (optional)..

CONTACT INFORMATION

RESIDENTIAL ADDRESS: ....

L.G.A OF RESIDENCE: ....

PHONE NUMBER: .... EMAIL ADDRESS: ....

MEDICAL INFORMATION

GENOTYPE: .... BLOOD GROUP: ....

ALLERGIES: .... ANY PRE-EXISTING MEDICAL CONDITION(S)? YES ☐ NO ☐

IF YES, STATE CONDITION(S)..

EDOHIS ID CARD: Physical Card ☐ Virtual Card ☐ (please, tick one box only)

DEPENDANTS INFORMATION

S/N	Surname	Name	Sex	Date of birth	Blood Group	Genotype	Phone Number
1 Spouse							
2							
3							
4							
5							

Dependants are made up of a spouse and 4 biological children under 18 years of age.

(Kindly submit the dependant's birth certificate and Marriage certificate before enrolment)