



OCEANIC HEALTH

MANAGEMENT LIMITED

Health Maintenance Organization

Company Name *	State*	Branch*

Designation*	Department*	Staff ID Number*

Surname	First name	Middle name

Residential Address

DOB Day*	Month*	Year*	Telephone

Type of Plan*	Active E-mail

Marital Status*	Number of children*	Blood Grp*	Genotype*

Choice of hospital *

Spouse's Name	Sex*	DOB*	Choice of Hospital*

Names of Children	Sex*	DOB*	Bld Grp*	Genotype*	Choice of Hospital*

Kindly indicate if any of your family currently live with any of the under listed conditions

Family Member	Principal	Spouse	01	02	03	04
Asthma						
Hypertension						
Cardiac Failure						
Epilepsy						
Diabetes						
Pregnancy						

Affix one passport photograph each of principal beneficiary and dependants with names on reverse.

Declaration:

I declare that to the best of my knowledge on behalf of all persons insured under this application that the information given above is accurate and forms the basis of the contract between the insured person and the HMO.

Signature	Date

NB: Disclosure of these conditions would determine the outcome of your application as undisclosed condition shall not be covered.

Hot line: **01-7100808**

Visit us on: www.oceanichealthng.com

Emergency Toll free lines: **08031230100; 08085897999.**

Send us emails on: customercare@oceanichealthng.com

Staff passport photo.

Spouse passport photo.

Child 1 passport photo.

Child 2 passport photo.

Child 3 passport photo.