

ENROLMENT FORM

"Liability of SONGHAI Health Trust Limited does not commence until this application is accepted, premium received and policy issued. Please NOTE that benefits may not be payable if you do not fully disclose any material facts which could influence our assessment and acceptance of this application and if you are in any doubt as to whether any facts are material, you should disclose them. This applies even if medical advice has not been sought. A material fact is one that is likely to affect the assessment of this application".

Company Name:			_ Nature of Business	s:
If you're applying as a corporate ent	ity, please insert the name of the	e company above.		
1. PERSONAL DETAILS (Principal)			
Surname:				
Date of Birth:	Gender:	Marital Status:		— [
Occupation:		in the artest	http://www.endline.com	ing an include
Genotype:	Blood Gr	oup:		
Residential Address: —			image f	<u>Coro</u> od) 2 TV040
		and the second second		
Phone:				
Name & Number of Ne				
Preferred Hospital: Contact details of the p				
Contact details of the p	referred Hospital (A	ddress/Telephone/E-n	nail):	
Contact details of the p 2. SPOUSE DETAILS Surname:	referred Hospital (A	ddress/Telephone/E-n	nail):	
Contact details of the p	referred Hospital (A	ddress/Telephone/E-n	nail):	
Contact details of the p 2. SPOUSE DETAILS Surname:	referred Hospital (A F Gender:	ddress/Telephone/E-n 	nail): Genotype:	
Contact details of the p 2. SPOUSE DETAILS Surname: Date of Birth:	referred Hospital (A	ddress/Telephone/E-n First Name: Blood Group:	nail): Genotype:	
Contact details of the p 2. SPOUSE DETAILS Surname: Date of Birth: Residential Address:	referred Hospital (A F Gender: E-mail:	ddress/Telephone/E-n First Name: Blood Group:	nail): Genotype:	
Contact details of the p 2. SPOUSE DETAILS Surname: Date of Birth: Residential Address: Phone:	referred Hospital (Ar F Gender: E-mail: _	ddress/Telephone/E-n	nail): Genotype:	
Contact details of the p 2. SPOUSE DETAILS Surname: Date of Birth: Residential Address: Phone: Preferred Hospital:	referred Hospital (Ar F Gender: E-mail: referred Hospital (Ar	ddress/Telephone/E-n	nail): Genotype:	
Contact details of the p 2. SPOUSE DETAILS Surname: Date of Birth: Residential Address: Phone: Preferred Hospital: Contact details of the p 3. DEPENDANT 1 (below	referred Hospital (Ar F Gender: E-mail: referred Hospital (Ar w 21 years)	ddress/Telephone/E-n First Name: Blood Group: ddress/Telephone/E-n	nail): Genotype: nail):	
Contact details of the p 2. SPOUSE DETAILS Surname: Date of Birth: Residential Address: Phone: Preferred Hospital: Contact details of the p	referred Hospital (Ar F Gender: E-mail: referred Hospital (Ar w 21 years)	ddress/Telephone/E-n First Name: Blood Group: ddress/Telephone/E-n First Name:	nail): Genotype: nail):	

Preferred Hospital: _

Contact details of the preferred Hospital (Address/Telephone/E-mail): _

4. DEPENDANT 2 (belo	w 21 years)			
Surname:	LIMITED	First Name:		_
Date of Birth:	Gender:	Blood Group:	Genotype:	-
Residential Address:				
			- MMOH	NOTWER
			and then the start is	
Preferred Hospital:		and the same different in		algoing box bevier
Contact details of the p	preferred Hospital (Ad	ddress/Telephone/E-mail	l):	
5. DEPENDANT 3 (below				(
		First Name:		
Date of Birth:	Gender:	Blood Group:	Genotype:	- Carriels (carrie
Residential Address:				-
			Principal)	NAMATAO NAMO 290
Preferred Hospital:		Testal? islam	192190	100
Contact details of the p	preferred Hospital (A	ddress/Telephone/E-mail	l):	Dottech
6. DEPENDANT 4 (belo	w 21 years)		10101	
		First Name:		_ (
Date of Birth:	Gender:	Blood Group:	Genotype:	-
Residential Address:				a to manufactor

Preferred Hospital: ____

Contact details of the preferred Hospital (Address/Telephone/E-mail): ____

Kindly request extra form to register extra dependant(s)

7. CATEGORY OF MEDICAL COVER (Please tick one box only)

SHTL Gold	Plus SHTL Gold	SHTL Silver	SHTL Classic	SHTL Stan	dard 🗌	
8. COMME	NCEMENT DATE:	dd mm (Date you want to	уууу commence)			
9. METHO	D OF PAYMENT:					
(i)	Cheque		(iv) SHTL Mobile	Арр		
(ii)	Bank Draft		(v) Internet Ban	king		
(iii)	Mobile Banking Transf	er				
(Disease)	المامه محم المت					

		Princ	cipal	Spo	ouse	Depen	dant 1	Depen	dant 2	Deper	ndant 3	Depend	dant 4
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
a.	Do you smoke?	i tanin	Dep 1	58001		ici pat	121						
b.	Has any person named in this form been admitted to a hospital or nursing home or had any medical test done in the last 2 years?	ON								so , daw Person Patrola Patrola			
C.	Has any specialist been consulted and/or provided prescriptions for any drugs or medication in the last 1 year?												
d.	Has any application for life, accident, health or any other insurance been refused or had special terms applied? If yes, give details												36
e.	Does any person named in this form anticipate the need or has been recommended to undergo any medical test or investigations in the foreseeable future? If yes, give details							6300					

Has any person named in this form ever suffered or is suffering from any disease or condition stated below?

10.51	un evig this en es anno servit	Prine	cipal	Spo	ouse	Depen	dant 1	Dependant 2		Dependant 3		Depen	dant 4
CHIT	hieralohae ya kinoi aidi a abia	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1.	High Blood pressure or circulatory disorders If yes underline					N S S S S S S S S S S S S S S S S S S S	CESTR	n assi Otina 1					150
2.	Stroke or Paralysis If yes underline								ita fre Izon			derstal ghai H	101
3.	Heart disease												
4.	Fainting, blackout, dizziness, seizures, fits, etc. If yes underline		(TRA		Torio	See.		iantes	0000			dengu	
5.	Stomach ulcer, hepatitis, gall bladder disease, intestinal or bowel disorders. If yes underline												
6.	Asthma, persistent cough, breathlessness or other respiratory disorders. If yes underline												
7.	Kidney, Bladder, Prostate or Genito-urinary disorders. If yes underline												
8.	Gynecological or hormone disorders. If yes underline												
9.	Diabetes, High Cholesterol or other blood disorders If yes underline						-	THE		20.3	a Ta	4212	
10.	Musculo-skeletal disorders												

Medical condition Cont'd

		Principal		Spouse		Dependant 1		Dependant 2		Dependant 3		Dependant 4	
-		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
11.	Tumour growth, cancer or glandular diseases. If yes underline							s o.t	itted home	n adn gnizu	m bei	his for iospita	
12.	Diseases or disorders of the eyes, ears, nose and throat. If yes underline									Sales Sales	1997	l sot n	
13.	Mental disorders								een) rovide			ini. 201 Nuzan	
14.	Any diseases, disorders or conditions which are long-lasting or recurrent. If yes underline							5120	1.22	i seti i	n non	nedica	
15.	Management for drug or substance abuse.							Tott	d hoh o yria	cation this or	19984 1997	nis son 1901-con	
16.	Any other illnesses, disabilities or defects that have not been mentioned above								109	an na Angas Aliati	renny Seriny	1612.90 (.29)	

If your answer to Question 16 above is YES, please provide details:___

11. DECLARATION

I hereby declare that the information given in this form is complete and true. I am aware that if I give false or misleading information deliberately, my enrollment may be rejected, or maybe terminated back to the date of this application. I am also aware that if I leave out important information in this form, my enrollment may be rejected. I am also aware that I must give true and complete information about my dependant(s) (spouse and children) otherwise, their enrollment may be rejected or terminated back to the date of this application.

I understand and agree that any dispute between myself (including any of my enrolled family members) and Songhai Health Trust must be subject to final and binding arbitration. I also understand that disputes that I may have with Songhai Health Trust involving claims for medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) are also subject to final and binding arbitration.

My signature below indicates that I understand and agree with the terms of this Agreement.

SIGNATURE OF APPLICANT