MEDICARE

ZENITH MEDICARE LIMITED

Principal Enrollee Photo Here

Effective Date: ____/____/____

ENROLLEE APPLICATION FORM
(GROUP PLANS)

Please complete in BLOCK LETTERS and return with a passport photograph of each beneficiary to Zenith Assurance Medicare

A. Personal Data

Surname | Middle Name | First Name

Title | Date Of Birth (DDMMYYYY) | Gender (M/F) | Marital Status *M/S/D/W | Blood Group

Residential Address **(Not P.O.Box)**

Telephone | Mobile | E-Mail

B. Employer Group Information

Name Of Company

Address Of Company (Head Office/ Branch)

Telephone | Designation | Dept/Division

C. Plan Option (Your selection must be offered by your employer)

Instant Health ☐ Smart Health ☐ Classic Health ☐ SuperHealth ☐ Deluxe Health ☐ FlexiHealth ☐

D. Individuals Covered

LIST ALL ELIGIBLE DEPENDENTS(First, Middle name)	GENDER M F	DATE OF BIRTH	PRIMARY PROVIDER	PRIMARY PROVIDER ID
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	☐ ☐			
	☐ ☐			
	☐ ☐			
	☐ ☐			
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E. Passport Photos

Spouse | Child | Child | Child | Child

Signature and Date

N.B Please inscribe name at the back of each passport photograph.

Declaration: I hereby apply to be enrolled in the Plan together with the Persons to be insured listed above. I declare that to the best of my knowledge on behalf of all persons to be insured under this application that I have read and understood fully the policy exclusions and conditions. It is agreed that this declaration and information given in this application shall form the basis of the contract (s) between the insured Person (s) and the HMO.