Enugu State Agency for Universal Health Coverage

Beneficiary Enrollment Form

1. PLAN TYPE
SSPHS ☐ BMPHS ☐

2. BENEFICIARY ID
☐☐☐-☐☐☐-☐-☐☐-☐☐-☐☐-☐☐-☐☐

3. BENEFICIARY NAME (Surname, First Name, Middle Name)(Exactly as on BVN)

4. DATE OF BIRTH
MM : DD : YYYY
SEX M ☐ F ☐

5. ADDRESS

8. BENEFICIARY TELEPHONE (Primary)

8a. BENEFICIARY TELEPHONE (Secondary)

9. BENEFICIARY EMAIL

10. BENEFICIARY GENOTYPE
AA ☐ AS ☐ SS ☐ SC ☐

11. BLOOD GROUP
0+ ☐ 0- ☐ A+ ☐ A- ☐
B+ ☐ B- ☐ AB+ ☐ AB- ☐

12. ALLERGIES

6. STATUS
Single ☐ Married ☐ Other ☐
Employed ☐ Full-Time Student ☐ Part-Time Student ☐

7. NAME OF EMPLOYER OR NAME OF SCHOOL

7a. ADDRESS OF EMPLOYER OR SCHOOL

7b. OCCUPATION

5a. LOCAL GOVERNMENT AREA
Aninri ☐ Awgu ☐ Enugu East ☐
Enugu North ☐ Enugu South ☐ Ezeagu ☐
Igbo Etiti ☐ Igbo Eze North ☐ Igbo Eze South ☐
Isi Uzo ☐ Nkanu East ☐ Nkanu West ☐
Nsukka ☐ Oji River ☐ Udenu ☐
Udi ☐ Uzo Uwani ☐

5b. WARD

14. SPOUSE NAME (Surname, First Name, Middle Name)

18. SPOUSE TELEPHONE (Primary)

18a. SPOUSE TELEPHONE (Secondary)

19. SPOUSE EMAIL

20. SPOUSE GENOTYPE
AA ☐ AS ☐ SS ☐ SC ☐

21. SPOUSE BLOOD GROUP
0+ ☐ 0- ☐ A+ ☐ A- ☐
B+ ☐ B- ☐ AB+ ☐ AB- ☐

22. SPOUSE ALLERGIES

15. SPOUSE DATE OF BIRTH
MM : DD : YYYY
SEX M ☐ F ☐

16. STATUS
Employed ☐ Full-Time Student ☐ Part-Time Student ☐

17. SPOUSE NAME OF EMPLOYER OR NAME OF SCHOOL

17a. SPOUSE ADDRESS OF EMPLOYER OR SCHOOL

17b. SPOUSE OCCUPATION

13. PRE-EXISTING CONDITION
Hypertension ☐ Glaucoma ☐ Asthma ☐
Cataract ☐ Diabetes ☐ Heart Disease ☐
Tuberculosis ☐ Cancer ☐ Duodenal Ulcer ☐
Peptic Ulcer ☐ Kidney Disease ☐ HIV/AIDS ☐
Fibroids ☐ Sickle Cell ☐ Epilepsy ☐
Arthritis ☐ Other ☐ ____________

23. PREGNANT / VULNERABLE
Pregnant Y ☐ N ☐ Vulnerable Y ☐ N ☐

27. DEPENDENT 01 NAME (Surname, First Name, Middle Name)

29. DEPENDENT 01 RELATIONSHIP TO BENEFICIARY

30. DEPENDENT 02 NAME (Surname, First Name, Middle Name)

32. DEPENDENT 02 RELATIONSHIP TO BENEFICIARY

33. DEPENDENT 03 NAME (Surname, First Name, Middle Name)

35 DEPENDENT 03 RELATIONSHIP TO BENEFICIARY

36. DEPENDENT 04 NAME (Surname, First Name, Middle Name)

38. DEPENDENT 04 RELATIONSHIP TO BENEFICIARY

26. NUMBER OF DEPENDENTS ☐☐

28. DEPENDENT 01 DATE OF BIRTH
MM : DD : YYYY
SEX M ☐ F ☐

28a. DEPENDENT 01 AGE ☐☐

31. DEPENDENT 02 DATE OF BIRTH
MM : DD : YYYY
SEX M ☐ F ☐

31a. DEPENDENT 02 AGE ☐☐

34. DEPENDENT 03 DATE OF BIRTH
MM : DD : YYYY
SEX M ☐ F ☐

34a. DEPENDENT 03 AGE ☐☐

37. DEPENDENT 04 DATE OF BIRTH
MM : DD : YYYY
SEX M ☐ F ☐

37a. DEPENDENT 04 AGE ☐☐

24. DISABILITY
Visual Impairment / Seeing ☐ Hearing Impairment ☐
Mobility ☐ Daily Life Activities ☐
Communication and Social Functions ☐ Intellectual and Learning Difficulties ☐
Behavioral and Psychological Difficulties ☐ Fits and Seizures ☐
Other ☐ ____________

25. EVER HAD SURGERY?
Y ☐ N ☐

25a. TYPE OF SURGERY

25b. YEAR OF SURGERY

41. BENEFICIARY NATIONAL IDENTITY CARD NUMBER (NIN)
☐☐☐☐☐☐☐☐☐☐☐

39. BENEFICIARY SIGNATURE

I hereby declare that all the information provided are all true to the best of my knowledge, and that I have not withheld any information. I agree to abide by the terms and conditions of the Enugu state universal health coverage scheme (ESUHCS)

SIGNED ____________ DATE ____________

40. BENEFICIARY RIGHT THUMB PRINT

42. ATTACH BENEFICIARY PASSPORT PHOTOGRAPH