FRM-INS-079

Health Insurance Enrollment Form

Health Insurance Enrollment Form

Please complete all sections of this form to ensure a smooth enrollment process. Your information will be kept confidential and used solely for the purpose of your health insurance application.

Personal Information

Full Name	
Date of Birth (DD/MM/YYYY)	
Gender	
National Insurance Number	
Address	
City	
Postcode	
Phone Number	
Email Address	

Employment Information	
Employer Name	
Employer Address	
City	
Postcode	
Occupation	

Dependents (if adding dependents to your plan)	
Dependent 1	
Full Name	
Relationship to Applicant	
Date of Birth	
Gender	❑ Male ❑ Female ❑ Other ❑ Prefer not to say

Health Information	
Do you smoke?	❑ Yes ❑ No
Do you have any pre-existing medical conditions?	❑ Yes ❑ No
If yes, please provide details	
Are you currently taking any medication?	❑ Yes ❑ No
If yes, please list	

Coverage Options	
Please select the type of coverage you are applying for	❑ Individual ❑ Couple ❑ Family ❑ Other (please specify)
Preferred Start Date of Coverage (DD/MM/YYYY)	

Beneficiary Information (optional)	
Beneficiary Name	
Relationship to Applicant	
Contact Number	

Payment Information	
Preferred Method of Payment	❑ Direct Debit ❑ Credit Card ❑ Other
Account Holder's Name	
Account Number	
Sort Code	

Declaration and Consent

By signing below, I declare that the information provided on this form is accurate and complete to the best of my knowledge. I consent to the use of my personal and health information as described above and in accordance with the privacy policy of [Insurance Company Name]. I understand that providing false or incomplete information may result in denial of coverage or termination of the insurance policy.

Signature: _____

Date: _____