



NATIONAL HEALTH INSURANCE SCHEME

MILITARY NHIS PROGRAMME BIO-DATA FORM



FORMAL SECTOR SOCIAL HEALTH INSURANCE PROGRAMME (FSSHIP)

INSTRUCTIONS: i) Use Black Biro Only, ii) Write in Capital letters

1. Personal Data:

Surname: First Name: Middle Name:

Rank: Service No: State of Posting: DOB:

Sex: Marital Status: (M/S/D/SP) Age: Blood Group: National ID (Personal Number): Telephone Number:

Residential Address (Not P.O.Box or P.M.B):

2. Employer

MOD

(for Retiree only)

NA

NN

NAF

(Tick as appropriate)

3. Primary Provider's Data:

Code/No / / Name

4. Alternative Primary Provider's Data:

Code/No / / Name

5. Medical History of Significance

(Medical condition that has been diagnosed which can be life threatening to the individual)

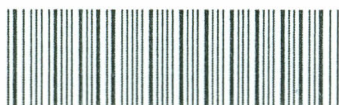
A. Diabetes B. Epilepsy C. Hypertension D. Sickle Cell Disease E. Allergies

6. One Spouse and Four Biological Children:

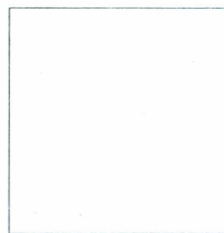
Medical History of Significance as in No.5 Tick box as appropriate

i. Spouse	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	First Name	Sex	Blood Group	Date of Birth		A	B	C	D	Alternative Provider
ii. Child 1	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	First Name	Sex	Blood Group	Date of Birth		A	B	C	D	Alternative Provider
iii. Child 2	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	First Name	Sex	Blood Group	Date of Birth		A	B	C	D	Alternative Provider
iv. Child 3	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	First Name	Sex	Blood Group	Date of Birth		A	B	C	D	Alternative Provider
v. Child 4	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	First Name	Sex	Blood Group	Date of Birth		A	B	C	D	Alternative Provider

Employee Use gum only to affix Photograph 3cm x 3.5cm	Spouse Use gum only to affix Photograph 3cm x 3.5cm	Child 1 Use gum only to affix Photograph 3cm x 3.5cm	Child 2 Use gum only to affix Photograph 3cm x 3.5cm	Child 3 Use gum only to affix Photograph 3cm x 3.5cm	Child 4 Use gum only to affix Photograph 3cm x 3.5cm
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MRF 20231



Thumb Print



Signature

NHIS/FS02

Date