NATIONAL HEALTH INSURANCE SCHEME

CHANGE OF HEALTHCARE FACILITY FORM

PHOTOGRAPH OF PRINCIPAL ENROLEE

PRINCIPAL ENROLEE ☐ DEPENDANT(S) ☐ BOTH ☐ (Please tick the appropriate box)

PRINCIPAL ENROLEE'S DETAILS:

SERVICE NO. | SURNAME | FIRST NAME | TELEPHONE NO.

RANK | NATIONAL IDENTITY NUMBER (NIN)

ID NUMBER | ELECTRONIC MAIL OF PRINCIPAL (if available)

FIRST NAME	OLD PROVIDER & CODE	NEW PROVIDER & CODE

REASON FOR CHANGE

PRINCIPAL ENROLEE'S SIGNATURE & DATE

FOR OFFICIAL USE ONLY

MODE OF REQUEST (Please Tick)

VISIT TO DHML ☐ POST ☐ OTHER (Please Specify)

……..	……	……
Receiving officer (Enrolment Officer)	Signature	Date
……..	……	……
Authorising Officer (State Manager)	Signature	Date
……..	……	……...
Effected by	Signature	Date

PHOTOGRAPH OF **SPOUSE**

PHOTOGRAPH OF **CHILD 1**

PHOTOGRAPH OF **CHILD 2**

PHOTOGRAPH OF **CHILD 3**

PHOTOGRAPH OF **CHILD 4**