



NATIONAL HEALTH INSURANCE EMPLOYER REGISTRATION FORM

Form A

PLEASE USE BLOCK LETTERS

BUSINESS NAME: _____

PARENT COMPANY NAME (IF ANY): _____

MAILING ADDRESS: _____

TELEPHONE NUMBER(S): (____)_____-____-____ | (____)_____-____-____ | (____)_____-____-____

BUSINESS ADDRESS: _____

TYPE OF BUSINESS: _____

BUSINESS EMAIL ADDRESS: _____

CONTACT INFORMATION OF OWNERS/PARTNERS/DIRECTORS (Use separate sheet for additional owners/partners/directors)

Name and Title	Address	Telephone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DECLARATION

I/We hereby apply for registration as an employer under the Social Security (Amendment) Act, 2014 and certify that the information provided is true and correct.

Name (please print) _____

Signature _____

Date _____

Office Held by Signatory _____

COMPANY STAMP

OFFICIAL USE ONLY

Officer's Name: _____

Signature: _____

Registration Number Assigned: _____

Date: D____ M____ Y ____