NATIONAL HEALTH INSURANCE
INDIGENT PERSON REGISTRATION FORM

Form G

INSTRUCTIONS

Please use block letters. Prior to submission the beneficiary **must** first be classified as an indigent person having met all the requisite criteria as required by the Department of Social Development. This form **must** be completed and approved by the Department of Social Development. ***A letter of verification from the Department of Social Development must accompany each registrants form.***

PERSONAL DATA (to be filled by employee)

LAST NAME: _____ MAIDEN NAME: _____ GENDER: MALE ☐

FIRST NAME: _____ MIDDLE NAME: _____ FEMALE ☐

VALID I.D. NUMBER: _____ | I.D. TYPE: PASSPORT ☐ | WORK PERMIT ☐ | BELONGER CARD ☐

COUNTRY OF ISSUE: _____ | ISSUE DATE: _____ | EXPIRY DATE: _____

MAILING ADDRESS: _____

EMAIL ADDRESS: _____ | TELEPHONE # (284)_____ | (284)_____

COUNTRY OF BIRTH: _____ | DATE OF BIRTH: Date: D___ M____ Y ____

OCCUPUATION: _____ | NHI MEMBERSHIP NUMBER: _____
(If previously registered)

MARTIAL STATUS: SINGLE ☐ | MARRIED ☐ | DIVORCED ☐ | WIDOWED ☐ | SEPARATED ☐ | COMMON-LAW-SPOUSE ☐ |

SPOUSE'S NAME: _____ | SPOUSE'S BIRTHDATE: D____ M____ Y ____

SPOUSE'S EMPLOYMENT STATUS: EMPLOYED ☐ | SELF-EMPLOYED ☐ | UNEMPLOYED ☐ | RESIDING OVERSEAS ☐ |

DATE OF MARRIAGE: Date: D____ M____ Y ____

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

Applicant's Signature …… **Date: D____ M____ Y ____**

INDIGENT STATUS GRANTED (to be completed by Department of Social Development)

INDIGENT PERIOD* FROM D____ M____ Y ___ TO D____ M____ Y ____

*Beneficiaries are to be reassessed every six months as required by the Director.

DEPARTMENT STAMP

Officer's Name _____

Officer's Signature …… **Date: D____ M____ Y ____**

OFFICIAL USE ONLY

Officer's Name:_____ Signature:_____

Registration Number Assigned: _____

Date: D____ M____ Y ____