VenusMedicare FORM 002VML VENUS MEDICARE LIMITED **ENROLLEE APPLICATION FORM** (GROUP ENROLLMENT) Please complete in BLOCK LETTERS and return with a passport photograph of each beneficiary to Venus Medicare A. Personal Data Gender Marital Status Title (WF) (M/S/WD) Surname **Blood Group** Genotype Other Names Principal Plan Type Enrollee Date Of Birth Individual Family Photo Primary Provider Here Telephone E-mail Plan Required: Deluxe Health Smart Health Classic Health Super Health Flexi Health **VMLPlan Employer Group Information** Name of Company Address of Company (Head Office/Branch) Dep/Division Telephone Designation Surname **Blood Group** Genotype Spouse Other Names Enrollee Date Of Birth **GENDER** Photo Here Primary Provider Telephone Sumame **Blood Group** Genotype Child 1 Other Names Photo Date Of Birth **GENDER** Here M/F Primary Provider Surname **Blood Group** Genotype Other Names Child 2 Photo Date Of Birth **GENDER** M/F Here Primary Provider Surname **Blood Group** Genotype Child 3 Other Names Photo Date Of Birth **GENDER** Here Primary Provider Surname Child 4 **Blood Group** Genotype Other Names Photo Here Date Of Birth **GENDER** Primary Provider Signature & Date N.B. Please inscribe name at the back of each passport Photograph

Declaration: I hereby apply to be enrolled in the Plan. I declare that to the best of my knowledge I have read and understand fully the policy exclusions and conditions. It is agreed that this declaration and information given in this application shall form the basis of the contract(s) between the insured person and the HMO VENUS MEDICARE CORPORATE HEAD QUARTERS: 131B Adetokunbo Ademola Crescent, Wuse II, Abuja, FCT. Tel: 09-4611380-6, 09-8705763 or 0805 391 5081, 09-2901155, E-mail: info@venusmedicare.com, WEBSITE: www.venusmedicare.com