TELEMEDICINE REGISTRATION FORM

HYGEIA HMO

Enrollee

Place a passport photograph here and print name on the reverse side

Company Name (if applicable): ____________________ **Division (if any):** ____________________

KINDLY FILL INFORMATION IN BLOCK LETTERS

Surname ____________________

First Name ____________________

Other Name ____________________

Date of Birth ____________________

Mobile Number ____________________

Email Address ____________________

DATA SUBJECT CONSENT STATEMENT

I hereby confirm that I have the legal capacity to give consent and hereby voluntarily grant my consent to Hygeia HMO Limited (Hygeia) and its duly appointed representatives, authority to access, retrieve, process, store, transfer as well as use for any legitimate and lawful purpose, my personal and/or medical information including all relevant data envisaged by the extant law including but not limited to the Nigerian Data Protection Regulation (and any amendment thereto) solely for the purpose of carrying out their duties and responsibilities as my health insurance Company. I confirm that I am aware of my rights, abilities and method to withdraw my consent herein at any time by notifying Hygeia HMO in writing and accordingly request that this consent remain in full force and subsist until such a time as when I withdraw same. In addition, I hereby grant same consent to Hygeia HMO on behalf of all my dependant(s) who are minors and accordingly request that this consent remain in full force and subsist until such a time as when I withdraw same or such a time when my dependent each personally withdraws same after attaining the statutory age of majority

Signature & Date: ____________________