National Health
INSURANCE BOARD

NHIB EMPLOYER ENROLLMENT FORM

Employer Group ID#: ____________________

Employer Group Name: ____________________

PLEASE USE BLOCK CAPITALS WHEN COMPLETING THIS FORM.

Employer Name:		Operational Date:	
DOB (mm/dd/yyyy):		Marital Status:	
Gender:	☐ Male ☐ Female	Occupation:	
Address:			
Island:			
Country:			
Phone:		Other Phone:	
Email Address:			
ID#			
No. of Employees:			

CONTACT PERSON(S)

1. Name:			
Title:		Company:	
Phone:		Other Phone:	
Email Address:			
2. Name:			
Title:		Company:	
Phone:		Other Phone:	
Email Address:			

Declaration by Employer: I, ______________________________(full name of employer) declare that the particulars provided in this enrollment form are to the best of my knowledge correct.

Signed by: ______________________ Date (mm/dd/yyyy): ______________________