NATIONAL HOSPITAL INSURANCE FUND
P. O. Box 30443 - 00100, NAIROBI, KENYA
Website: www.nhif.or.ke Email: info@nhif.or.ke

Folio No: .....

REGISTRATION FORM

Tick where applicable ☐ **Employed** ☐ **Self Employed** ☐ **Organized Groups** ☐ **Sponsored**

Tick where required ☐ **Registration** ☐ **Choice/Change facility**

Guidelines:

1. **Attach Copies of Identification cards for both the contributor and spouse.**
2. **For new registration of employed persons attach an introduction letter from employer.**

PART I: MEMBER DETAILS

Surname: ..... Other Names: .....
NHIF No: ..... National I.D/Passport/Alien I.D No.: .....
Date of Birth (DD/MM/YYYY): ..... Gender (Male/Female): .....
Employer/Organized Group Code: ..... Sponsor Code: .....
Payroll/Personal No.: ..... Mobile Phone No.: .....
Place of Residence (sub county): .....
E-Mail Address: .....
Postal Address: ..... Post Code: .....

PART II: SPOUSE DETAILS

Surname: ..... Other Names: .....
National I.D./Passport/Alien I.D. No.: ..... Date of Birth (DD/MM/YYYY): .....
Gender (Male/Female): ..... Mobile Phone No.: .....

PART III: CHILDREN DETAILS AND CHOICE/ CHANGE OF FACILITY

Guidelines:

1. **Please attach a copy of Birth Certificate for each child. For children under six (6) months, a birth notification is acceptable.**
2. **To choose an outpatient medical facility, please refer to the list of our accredited outpatient health facilities available in the N.H.I.F Website and Offices countrywide.**
3. **To access benefits one MUST be a duly registered member and must have declared their dependant.**
4. **To choose an OPC Facility, attach a copy of the contributor's National ID**

	Name	Date of Birth				Preferred Medical Facility	
		Date	Month	Year	Gender M/F	Code	Name
PRINCIPAL							
SPOUSE							
CHILD 1							
CHILD 2							
CHILD 3							
CHILD 4							
CHILD 5							
CHILD 6							
CHILD 7							
CHILD 8							
CHILD 9							
CHILD 10							

PART IV: PHOTOGRAPHS

Please attach one coloured passport size photo for each of the persons named in part I, II and III. Indicate the name of the person and contributor's I.D. Number at the back of the individual passport size photo.

CONTRIBUTOR	SPOUSE	1st CHILD	2nd CHILD
Contributor's Name:	**Spouse's Name:**	**Child's Name:**	**Child's Name:**
.....	.....	.....	.....
.....	.....	.....	.....

3rd CHILD	4th CHILD	5th CHILD	6th CHILD
Child's Name:	**Child's Name:**	**Child's Name:**	**Child's Name:**
.....	.....	.....	.....
.....	.....	.....	.....

7th CHILD	8th CHILD	9th CHILD	10th CHILD
Child's Name:	**Child's Name:**	**Child's Name:**	**Child's Name:**
.....	.....	.....	.....
.....	.....	.....	.....

PART V: CHANGE OF OUTPATIENT HEALTH FACILITY

Guidelines:

1. **For change of medical facility please fill PART III to indicate your preferred medical facility.**
2. **Attach a copy of the Principal Members National ID**
3. **Please tick in the table below reasons of change where applicable.**

01	Transferred to a new workstation	
02	Unavailability of 24 hours service	
03	Requested to buy prescribed drugs	
04	Unavailability of dental services **(if applicable**)	
05	Unavailability of optical services **(if applicable**)	
06	Lack of specialized services	
07	Bad attitude from clinic staff	
08	Current facility stopped offering services	
09	Other reasons (please specify)	

PART VI: DECLARATION

I hereby declare that the above information is correct to the best of my knowledge.

Name ..... Sign..... Date .....

Official Rubber Stamp.....

FOR OFFICIAL USE ONLY

1. Receiving Officer _____ Sign _____ Date _____

2. Authorization Officer _____ Sign _____ Date _____

3. Data Capture Officer _____ Sign _____ Date _____