



INTERNATIONAL HEALTH MANAGEMENT SERVICES  
2 JOSEPH STREET, LAGOS  
01- 2646318, 2633632 2645160 Fax: 2600700

**CHANGE OF HOSPITAL FORM**

NAME OF ENROLLEE .....

TEL NO..... E-MAIL .....

COMPANY / ORGANIZATION .....

DEPARTMENT..... BRANCH .....

**PLAN TYPE** (Please tick as appropriate)

BASIC

STANDARD

STANDARD PLUS

COMPREHENSIVE

IHMS ENROLLEE IDENTITY CARD NO .....

PRESENT HOSPITAL .....

PREFERRED HOSPITAL .....

REASON FOR CHANGE

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.....  
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*(Please use additional sheets if necessary and attach)*

ENROLLEE'S SIGNATURE ..... DATE.....

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**FOR OFFICIAL USE ONLY**

DATE RECEIVED..... DATE CHANGED.....

NAME OF OFFICER .....

SIGNATURE..... COMMENT .....