OGUN STATE HEALTH INSURANCE AGENCY

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THIRD PARTY ADMINISTRATOR REGISTRATION FORM

Name of Organization: ……..…….

……..

Address: …….…….....

……..……

State…… **LGA**……..**Ward**……..

Telephone Number: ……..

E-Mail…….....

Does the organization have an annex? Yes ☐ No ☐

If yes, address of the annex and distance from main location:

……

……

Name of Director/Chairperson:……

Phone No. ……..

Name of Health Insurance Desk Officer (if any): ……

Phone No. ……..

PLEASE ATTACH:

I. **Certificate of incorporation from CAC.**
II. **Evidence of registration with relevant regulatory agencies.**
III. **Organization's profile.**

DECLARATION

I/We agree with the consideration for the engagement of our organization by Ogun State Health Insurance Agency (OGSHIA). If our organization meets the Agency's requirements, the terms and conditions of engagement will be communicated to me/us for my/our consideration and acceptance. These may be reviewed from time to time to meet changing needs and circumstances.

I/We declare that to the best of my/our knowledge and belief, all the information I/We have provided in this registration form is true and complete. On that basis, I/We now formally apply to join OGSHIA network of TPAs. I/We understand that I/We have the choice to opt out of the Scheme which shall be effected within 28 days of notifying the Agency in writing.

Name:…….. Name:……

Signature:…….....Signature:.....

Designation:……..…Designation:……..

Date: ……Date:……...……

NB:
Access to information on your organization, its proprietors, staff, clients, or operational performance may be granted by OGSHIA to others on a strictly confidential basis in the course of, and for the purpose of, the efficient Administration of OGSHIA Scheme (for example, in connection with statutory requirements, audits, systems development or improving our service). Anonymized data may be disclosed to others for research or statistical purpose.