

Hibernian Health Information Sheet

Name: _____

Address: _____

Contact Number: Home/Work: _____

Mobile: _____

Email: _____

Current Health Insurance Provider (Please Tick Box):

Hibernian Health

Quinn Health/BUPA

VHI

None

Existing Plan (e.g. VHI Plan B Options etc.) _____

Personal Details:

	Name	Date of Birth	Occupation	Relationship to Insured
1.		--/~/----		
2.		--/~/----		
3.		--/~/----		
4.		--/~/----		
5.		--/~/----		
6.		--/~/----		
7.		--/~/----		

Fax or email details back to us at 01-2842346 or info@affinityinsurance.ie