



Application Form

Account Details (To be completed in Block Letters)

Medical Aid Group Number:
Corporate Name:
Postal Address:
Physical Corporate Address:
E-mail Address:
Surname:
First Names:
Title:
Work Phone: () Fax: ()
Cell Number:
Preferred date of installation:
FOR OFFICE USE ONLY
Submitted by:
Login:
Password:
Comments:

System Requirements for e-HEALTH Access

- Windows 95/98/2000
- Internet Explorer Version 4.0 or Higher / Netscape
- Modem (28800 Kbs) / Internet Connectivity

Signature: _____ Date: ____/____/____

**Send to: Information Systems Department
METHEALTH NAMIBIA ADMINISTRATORS**

FAX: (061) 287 6024

TEL: (061) 287 6000

E-mail: isdept@methealth.com.na

INDEMNITY CLAUSE

Since all claims history will be updated weekly, no responsibility can be accepted by Methealth Namibia Administrators (PTY) LTD for outstanding claims that have not been registered at the time of access to the Internet.