



## MEMBER RECORD AMENDMENT

PLEASE COMPLETE ALL THE APPLICABLE SECTIONS IN FULL

- Addition of dependants  
 Termination of employment / resignation  
 Removal of dependants  
 Change bank account details

### A. PARTICULARS OF PRINCIPAL MEMBER (Please print in block letters)

MEMBERSHIP NUMBER:

ID/PASSPORT NO:

TITLE: Prof/Dr/Mr/Mrs/Miss etc.  SURNAME:

FIRST NAME/S:

POSTAL ADDRESS:  STREET ADDRESS:

HOME - TEL. CODE & NO.:  WORK TEL. CODE & NO.:  CELL NO.:

DATE OF BIRTH:  FAX NO.:  MARITAL STATUS:  SINGLE  MARRIED  DIVORCED  WIDOWED

E-MAIL ADDRESS:  DATE ON WHICH CHANGE WILL BECOME EFFECTIVE:

### B. ADDITION OF DEPENDANT/S, SPECIAL DEPENDANT/S, ADOPTIONS AND/OR NEWBORN CHILDREN

Husband, wife and children under 21 years, who are unmarried and not in full employment. Children up to 25 years may be included if they are financially dependent and full-time students at a recognized educational institution\*. Attach proof of registration. For more than three (3) dependants, please attach a list. (If legally adopted, please attach necessary documents).

*\* Recognized educational institution as per the rules of Namibia Medical Care.*

Full first names	Surname (if different than principal member)	Sex M/F	Occupation	ID/Passport Number	
				Date of birth	Rest of ID/Passport No.
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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### C. CHANGE OF MARITAL STATUS

If married, attach certified copy of Marriage Certificate. If divorced, attach certified copy of decree of divorce and a complete copy of statement stating that the member is responsible for medical costs of children. In case of death, attach certified copy of death certificate.

Please mark the applicable block with an X  MARRIED  DIVORCED  WIDOWED DATE OF MARRIAGE/DIVORCE/DEATH:

If married: SPOUSE TITLE:  SURNAME:

FIRST NAME/S:

### SPOUSE MEDICAL COVER PARTICULARS

Is/was your spouse a member of a registered medical aid fund uninterruptedly for the past two years?  YES  NO

NAME OF PRESENT MEDICAL AID FUND  MEMBERSHIP NO.

PERIOD OF MEMBERSHIP: FROM:  TO:

NAME OF PREVIOUS MEDICAL AID FUND  MEMBERSHIP NO.

PERIOD OF MEMBERSHIP: FROM:  TO:

Was membership subject to any restrictions/exclusions?  YES  NO If yes, state particulars of restrictions:

**D. REMOVAL OF DEPENDANTS**

Please note that in case of divorce, legal documentation is required:

DEPENDANT SURNAME:  TITLE: Prof/Dr/Mr/Mrs/Miss etc.

FIRST NAME/S:

IDENTITY NUMBER:  EFFECTIVE DATE:

REASON: \_\_\_\_\_

**E. DEATH OF MEMBER**

Does the widow(er)/eldest dependant wish to continue on the medical aid and become the principal member?

EFFECTIVE DATE:  (Please attach certificate copy of death certificate)

**F. TERMINATION OF EMPLOYMENT/RESIGNATION**

REASON: \_\_\_\_\_

RESIGNATION/RETRECEMENT DATE:  Would you like to continue membership with NMC? (If you belonged to an employer group)

**G. BANK ACCOUNT DETAILS**  ELECTRONIC FUND TRANSFER  OR  DEBIT CARD

NAME OF ACCOUNT HOLDER:

ACCOUNT NO.:

BANK:  BRANCH:

TYPE OF ACCOUNT:  CHEQUE  SAVINGS\*  TRANSMISSION:  8-DIGIT BRANCH CODE:

ID/PASSPORT NUMBER:  DATE OF FISRT DEDUCTION:

I authorise Namibia Medical Care to draw from bank account, the premiums (and any stamp duty or short payments) due in terms of the Medical Scheme, without prejudice to the rights of Namibia Medical Care. I further authorise Namibia Medical Care to increase the amounts due to it in terms of the policy from time to time and authorise my bank to effect payment of such increased amount upon receipt of a written notice from Namibia Medical Care stating the increased amount and the date from which it is payable. This authorisation is to remain in force until cancelled by me by giving written notice to Namibia Medical Care.

I agree that I am not entitled to recover any amount drawn from my account by means of this debit order and that should my bank repay such amount to me, I will refund it to Namibia Medical Care. I undertake to notify Namibia Medical Care of any change in respect of my address or bank.

NAME	SIGNATURE OF ACCOUNT HOLDER	DATE

**J. UNDERTAKING BY THE APPLICANT**

- I, the undersigned, apply for amendments to my Namibia Medical Care membership, as indicated above and agree that all answers and information contained in this application and all documents which, in Namibia Medical Care's opinion, are relevant to the risk and which are signed or will be signed by me, shall be the basis of my membership and that shall be warranted as true and complete; and that my membership shall be void if any information should be inaccurate or incomplete, in which event all moneys paid towards the membership shall be forfeited to Namibia Medical Care, and all benefits paid shall immediately be repayable to Namibia Medical Care; My membership shall not be amended unless Namibia Medical Care specifically notifies me in writing of their acceptance of the risk; and any deterioration or change of the state of my health or the health of my dependants before the date of occurrence set by Namibia Medical Care for the commencement of the change in membership or the date which the amendments as applied for in this document are accepted by Namibia Medical Care, shall give Namibia Medical Care the right to reconsider the amendments and to propose new terms of acceptance or to declare the membership null and void in which event all moneys paid towards this membership before Namibia Medical Care receives notice of such a change shall be forfeited to Namibia Medical Care and benefits paid shall immediately be repayable to Namibia Medical Care.
- I irrevocably give my consent to my medical doctor, person or organisation, who may posses, or may come in possession of any information regarding my health or the health of my dependants, to disclose this information to Namibia Medical Care, also after my death.
- I give my consent to my employer in the case of group membership, to deduct from my salary and pay Namibia Medical Care all amounts that may be due by me to Namibia Medical Care.

Signed at \_\_\_\_\_ on the \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_

SIGNATURE OF WITNESS	DATE	SIGNATURE OF APPLICANT

COMPANY STAMP

APPROVAL BY COMPANY  
(Signature of Company Official)

DATE