FAXED APPLICATION FORMS ARE NOT ACCEPTABLE

NMC
NAMIBIA MEDICAL CARE

Namibia Medical Care
P.O. Box 24792
Windhoek, Namibia
Tel. (061) 287 6000
Email: membership@methealth.com.na

APPLICATION FOR MEMBERSHIP

(Read addendum notes before completing the form)

PLEASE COMPLETE ALL THE APPLICABLE SECTIONS IN FULL

Applicant's Status — **Principal Member** ☐ **Additional Dependant** ☐ **Special Dependant** ☐

A. BENEFIT OPTION

Topaz ☐ **Topaz Plus** ☐ **Topaz Plus Student** ☐ **Opal** ☐ **Jade** ☐ **Ruby** ☐ **Sapphire** ☐

Diamond ☐ **Emerald** ☐ (Hospital cover only) **Emerald Plus** ☐ (Hospital cover with optional day-to-day benefits) **Amber** ☐ (Hospital cover only) **Amber Plus** ☐ (Hospital cover with optional day-to-day benefits)

VOLUNTARY CONTRIBUTIONS

Indicate with an X:

Monthly Voluntary Contribution	N$300	☐	N$600	☐	N$900	☐	N$1,200	☐	N$1,500	☐
Extended Benefit Per Year	N$3,600	☐	N$7,200	☐	N$10,800	☐	N$14,400	☐	N$18,000	☐

Membership Start Date (D D M M Y Y) — Are you applying as an individual (Private Member)? ☐ — Or as a member of an Employer Group? (Please Complete Section K) ☐

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

TITLE (Prof/Dr/Mr/Mrs etc.) — SURNAME

FIRST NAME

DATE OF BIRTH (D D M M Y Y) — GENDER (M F) — ID/PASSPORT NO.

NATIONALITY — MARITAL STATUS (SINGLE / MARRIED / WIDOWED / DIVORCED)

OCCUPATION (Indicate if you are a Pensioner) — GROSS MONTHLY INCOME (N$) (Compulsory for Opal)

POSTAL ADDRESS — STREET ADDRESS

POSTAL CODE

TEL. (HOME) — TEL. (WORK)

CELL NO. — FAX:

EMAIL ADDRESS (Principal Member) — EMAIL ADDRESS (Spouse (if applicable))

FOR OFFICE USE ONLY

UNDERWRITING DECISIONS — PRORATED BENEFITS (Yes / No)

EXCLUSIONS — CONFINEMENT WAITING PERIOD (Yes / No)

MEMBERSHIP NUMBER — OPTION — REGISTRATION DATE: (D D M M Y Y)

PREMIUM (N$) — PAYMENT METHOD (CASH / DEBIT ORDER / EFT / GROUP)

BENEFIT DATE ON DAY-TO-DAY BENEFITS D D M M Y Y | INDIVIDUAL MEMBERSHIP | GROUP CODE | GROUP NAME:

PROCESSING DATE D D M M Y Y | CLERK (INITIALS) | SENIOR / TEAM LEADER (INITIALS AND DATE)

C. EMPLOYER DETAILS

COMPANY NAME

ADDRESS

TEL. | FAX

D. PARTICULARS OF PREVIOUS MEDICAL COVER

Were/Are you a member/dependant of a Namibian registered medical aid fund for the past two years? If 'yes', please attach a certificate(s) of membership from your current/previous medical aid fund (a membership card is not sufficient). Yes No

NAME OF CURRENT MEDICAL AID FUND _____ MEMBERSHIP NO.

PERIOD OF MEMBERSHIP: FROM D D M M Y Y TO: D D M M Y Y

NAME OF PREVIOUS MEDICAL AID FUND _____ MEMBERSHIP NO.

PERIOD OF MEMBERSHIP: FROM D D M M Y Y TO: D D M M Y Y

Was membership subject to any restrictions/exclusions? Yes No If yes, state particulars of restrictions _____

E. PARTICULARS OF DEPENDANTS

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 full-time students at a recognised educational institution*. Attach proof of registration. Please attach a list for more than five (5) children. (If legally adopted, please attach the necessary documents). If surnames differ from that of Principal Member, please provide documentary proof of relationship.

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

Dependants	First Name	Surname (if different from principal member)	Gender M/F	Occupation	ID/Passport Number	
					D.O.B	ID/Passport No.
Spouse						
1st Child						
2nd Child						
3rd Child						
4th Child						
5th Child						

F. STATE OF HEALTH

TO BE SUPPLIED BY MEMBER/APPLICANT (COMPULSORY)

Please provide the name and address of your general practitioner, dentist, as well as any specialist you may have consulted recently.

Dentist _____ **Doctor** _____ **Specialist** _____

Tel. _____ **Tel.** _____ **Tel.** _____

Please complete the questionnaire by placing an X in the answer box that corresponds to your response.

Have you, your spouse or any dependants ever experienced any of the following:

1. Any disorder of the heart (e.g. angina, heart attack, heart murmur, rheumatic fever, coronary artery disease, chest pain, shortness of breath, palpitations, congenital disorders, etc.)? Yes No
2. High blood pressure or disease of the blood vessels or circulatory disorder (e.g. high cholesterol, stroke, thrombosis, cramps in the calves with exercise or walking etc.)? Yes No
3. Any respiratory or lung disease/disorder (e.g. asthma, bronchitis, tuberculosis, persistent cough)? Yes No
4. Any disorder of the digestive system, gall bladder, pancreas or liver (e.g. hiatus hernia, recurrent indigestion, suspected gastric or duodenal ulcer, rectal bleeding, piles or jaundice or have you ever had a gastroscopy)? Yes No
5. Disease or disorder of the kidney, bladder or reproductive organs (e.g. protein in the urine, kidney stones, nephritis, prostatitis, cystitis or sexually transmitted disease)? Yes No

6.	Diabetes, thyroid or other glandular or blood disorders (e.g. anaemia or bleeding disorders, leukaemia, haemophilia)?	Yes	No
7.	Eye, ear, nose or throat disorder (e.g. defective vision, hearing loss, ear discharge, recurrent tonsillitis, hoarseness, retinitis pigmentosa, glaucoma)?	Yes	No
8.	Nervous or mental complaint (e.g. epilepsy, blackout, paralysis, anxiety state or depression, chronic headaches, fits, fainting, multiple sclerosis, brain impairment)?	Yes	No
9.	Disorder or disease of the skin eruption, (e.g. porphyria, psoriasis, dermatitis, muscles, bones, joints, limbs or spine, e.g. rheumatism, arthritis, gout, slipped disc or other back condition)?	Yes	No
10.	Any tropical disease (e.g. bilharzia, malaria, brucellosis)?	Yes	No
11.	Cancer, a growth or tumor of any kind?	Yes	No
12.	Any other illness, disorder or operation, disability or accident, (INCLUDING MOTOR VEHICLE ACCIDENTS) which required medical, radiological, surgical, pathological investigations, or have you ever been hospitalised?	Yes	No
13.	Do you or any of your dependants have any physical (including dental), abnormality, deformity, handicap or defect, whether congenital or as a result of an accident, disease or some other cause? For dental system (poor closure of jaws, implants, orthodontic, periodontic or maxillofacial surgery).	Yes	No
14.	Are you or your dependants currently undergoing or expecting to undergo any medical, dental, or surgical treatment?	Yes	No
15.	Are you or any of your dependants pregnant? If yes, state expected date of delivery.	Yes	No
	If the answer to question 15 is YES, please answer the following questions:		
15.1.	Did you or any of your immediate family e.g. mother, dependants, sister experience any complications with previous pregnancies?	Yes	No
15.2.	Are there any complications or health problems detected in you or your immediate family 's current pregnancy or that of the unborn baby?	Yes	No
16.	Does any member of your (or your spouse's) immediate family e.g. parents, brothers or sisters suffer from diabetes, heart disease, high blood pressure, raised cholesterol, mental disease, porphyria or any other disease?	Yes	No
17.	Did you experience any health problems or show signs and symptoms of health problems in the last 3-months before applying for membership?	Yes	No
18.	Has your weight or the weight of your spouse/dependant changed more that 5kg in the last 12 months? If so, why?	Yes	No
19.	Are you or your dependants smokers?	Yes	No
20.	Are there any addictions we should be aware of?	Yes	No

21.	Height & weight (Principal member)	Height		Weight
	Height & weight (Spouse)	Height		Weight
	Height & weight (child 1)	Height		Weight
	Height & weight (child 2)	Height		Weight
	Height & weight (child 3)	Height		Weight
	Height & weight (child 4)	Height		Weight
	Height & weight (child 5)	Height		Weight

If you have answered 'yes' to any of the above questions please provide the full details below:

Question No.	Beneficiary (Name of Person)	Illness or condition	Date and duration of the illness or condition	Date and nature of treatment received medical or surgical result of treatment	Name of doctor, hospital or institution	Treatment recommended: likely date and duration of treatment

If more space is needed, please attach list.

Declaration of the Applicant's Family Doctor:
I confirm that the information supplied by the applicant in Section F, State of Health, is true and correct.

DOCTOR'S FULL NAMES ______________________ PRACTICE NUMBER ______________

SIGNATURE ______________________ DATE ______________

G. CHRONIC MEDICATION

Do you or any of your dependants use chronic medication? Yes ☐ No ☐

*An application form for the CHRONIC MEDICATION BENEFIT must be completed before any benefit can be received. (Form obtainable from the NMC website, www.nmcfund.com or your nearest Client Services Office.)

Beneficiary	Diagnosis	Prescribed Medication	Strength	Dosage	Period Medication Used
					From D D M M Y Y To D D M M Y Y
					From D D M M Y Y To D D M M Y Y
					From D D M M Y Y To D D M M Y Y
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					From D D M M Y Y To D D M M Y Y
					From D D M M Y Y To D D M M Y Y

Declaration of the Applicant's Family Doctor:
I confirm that the information supplied by the applicant in Section G, Chronic Medication, is true and correct.

DOCTOR'S FULL NAMES ______________________ PRACTICE NUMBER ______________

SIGNATURE ______________________ DATE ______________

H. YOUR BANKING ACCOUNT DETAILS (Required for refunds to be deposited directly into account)

ACCOUNT HOLDER'S NAME

ACCOUNT NO.

BANK TYPE OF ACCOUNT: CURRENT ☐ SAVINGS ☐

BRANCH NAME BRANCH CODE

Please note:
- *a bank account confirmation letter is required; and*
- *no post office savings accounts are allowed*

NAME SIGNATURE OF ACCOUNT HOLDER DATE

I. DEBIT ORDER (Required for authorisation of deduction of monthly contributions from bank account) (ONLY FOR INDIVIDUAL MEMBERSHIP)

ACCOUNT HOLDER'S NAME

ACCOUNT NO.

BANK TYPE OF ACCOUNT: CURRENT ☐ SAVINGS ☐

BRANCH NAME | BRANCH CODE

ID NUMBER | DATE OF LAST DEDUCTION (D D M M Y Y)

I authorise Namibia Medical Aid to debit my bank account (wherever it may be), for premiums (and any stamp duty or short payments) 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 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 through written notice to Namibia Medical Care.

I agree that I am not entitled to recover any amount debited from my account by means of this debit order and that should my bank reverse any such amount, I will refund Namibia Medical Care. I undertake to notify Namibia Medical Care of any changes to my address or bank details.

NAME | SIGNATURE OF ACCOUNT HOLDER | DATE

J. UNDERTAKING BY THE APPLICANT

1. I, the undersigned, apply for the membership of Namibia Medical Care 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 they 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 the money paid towards the membership shall be forfeited to Namibia Medical Care and all benefits paid shall immediately be payable to Namibia Medical Care.

   My membership shall not commence 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 due date or the occurrence set by Namibia Medical Care for the commencement of the membership or the date on which this application is accepted by the Namibia Medical Care, or the date of receipt of the first subscription whichever is the latest date, shall give Namibia Medical Care the right to reconsider the application and to propose new terms of acceptance or to declare the membership null and void, in which event all the money 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 hereby agree to abide by the Rules of Namibia Medical Care as required by Act 23 of 1995 and approved by NAMFISA.
2. I irrevocably give my consent to my medical doctor, person or organisation, who may possess, 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, including after my death.
3. 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 to Namibia Medical Care. I commit to familiarise myself with the Fund's rules and to adhere to them.
4. I commit to familiarise myself with the Fund's rules and to adhere to them.

Signed at _____ on the _____ day of _____ 20 _____

WITNESS | DATE | APPLICANT'S SIGNATURE

K. EMPLOYER'S DECLARATION CONCERNING GROUP SCHEME APPLICANT

I/We declare that

was appointed as a full-time employee on (D D M M Y Y) and is entitled to membership of the group scheme number

from (D D M M Y Y) The monthly subscription of N$ will be paid from (D D M M Y Y)

Payroll Number _____

COMPANY OFFICIAL'S SIGNATURE | DATE | EMPLOYER'S STAMP

ADDENDUM TO NAMIBIA MEDICAL CARE APPLICATION FOR MEMBERSHIP FORM (for all applicants)

Thank you for applying for membership with our Fund. To ensure your relationship with Namibia Medical Care remains satisfactory for the duration of your registration as a member, it is important that you comply with the following requirements:

1. The application form must be COMPLETED IN FULL, i.e. all requested information must be provided. Please do not leave any spaces blank or delete sections without first reading and supplying the required information.
2. Section F of the application is important; thus, all required information must be provided. ANY INFORMATION PROVIDED THAT IS NOT TRUE/INCOMPLETE/NOT DISCLOSED could have SERIOUS REPERCUSSIONS in your future association with the Fund.
3. No medical examinations, etc., are necessary at this stage of your application, but we encourage you to submit copies of your medical reports to support your application.
4. Please note that all day-to-day benefits (Category B) for members joining as individuals will be pro-rated for the first three months.
5. The Fund rules stipulate that a member will be classified as a member of an "EMPLOYER GROUP" if his/her membership is derived from the participation in the FUND of an EMPLOYER who employs at least twenty EMPLOYEES. An "EMPLOYER GROUP" will be classified as a voluntary group if at least 70% of the employees of the group who are eligible to belong to a medical aid fund join NMC.
6. If you are NOT joining the Fund on 1 January, you will have PRO-RATA day-to-day benefits.
7. No benefits are available for any exclusions/restrictions placed on the principal member and/or his/her dependants from the date of registration. These exclusions/restrictions will be first communicated to the principal member for acceptance prior to registration.
8. DO NOT RESIGN FROM YOUR PRESENT MEDICAL AID FUND until you receive formal communication that your application has been approved.
9. Required Documents (*all photocopies must be clear and legible*):
   - ID/Passport
   - Full Birth Certificate
   - Marriage Certificate
   - Banking Account Confirmation Letter (*Not older than six months.*)
10. None payments are to be handed over for debt collection.
11. Principal members/dependents may withdraw from the Fund by providing the Fund with one calendar month's written notice.

NAME | SIGNATURE OF ACCOUNT HOLDER | DATE