Namibia Medical Care
P.O. Box 24792
Windhoek, Namibia
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MEMBER RECORD AMENDMENT

PLEASE COMPLETE ALL THE APPLICABLE SECTIONS IN FULL

Addition of Dependant ☐ Termination of Employment/Resignation ☐ Group Change ☐

Removal of Dependants ☐ Change Bank Account Details ☐ Individual's Status ☐

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

Membership No. | ID/Passport No.

Title (Prof/Dr./Mr./Mrs. etc.) | Marital Status: Single / Married / Divorced / Widowed | Date of Birth: D D M M Y Y

First Name | Surname

Postal Address | Street Address

Tel. (Home) | Tel. (Work)

Cell No. | Fax.

Email Address | Effective Date: D D M M Y Y

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 recognised educational institution.* Attach proof of registration. For more than three(3) dependants, please attach a list. (If legally adopted, please attach the necessary documents). *Recognised educational institutions as per the Fund's rules.

Full First Name	**Surname** (if not the same as principal member's)	**Gender (M/F)**	**Occupation**	**ID/Passport No.**	**Date of Birth**

C. ADDITION OF DEPENDANT(S), SPECIAL DEPENDANT(S), ADOPTIONS AND/OR NEWBORN CHILDREN

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 the medical costs of children. In case of death, attach certified copy of death certificate.

Please mark applicable block with an X: Married / Divorced / Widowed | Date of Marriage/Divorce/Death: D D M M Y Y

If Married: Spouse's Title: (Prof/Dr./Mr./Mrs. etc.) | Surname

First Name

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 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 _____

D. REMOVAL OF DEPENDANTS

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

Dependant's Surname | Title (Prof/Dr./Mr./Mrs. etc.)

First Name

ID/Passport No. | Effective Date D D M M Y Y

Reason _____

E. DEATH OF MEMBER

Does the widow(er)/eldest dependant wish to continue on the medical aid and become the Principal Member? Yes No

Effective Date D D M M Y Y (Please attach certified copy of death certificate)

F. TERMINATION OF EMPLOYMENT/RESIGNATION/GROUP CHANGE/INDIVIDUAL STATUS

Reason (Select One)

- ☐ Employer's Request (Misuse of benefits)
- ☐ Member's Request
- ☐ Group Resigned
- ☐ Employee Resigned
- ☐ Member Left the Country
- ☐ Member Joined the Spouse
- ☐ Member Joined Other Fund (Split Group)
- ☐ Contract Terminated
- ☐ Dismissal
- ☐ Non-Payment: Individual Member
- ☐ Non-Payment: Group
- ☐ COVID-19 (Income lost due to the pandemic)
- ☐ Income lost due to ill-health
- ☐ Member Deceased
- ☐ Waiver Lapsed (Family cover expired (three months after the main member's death))
- ☐ Service Challenges (The Fund is not meeting the member's expectations)
- ☐ Correction of Premium Error (Request for refund)
- ☐ Affordability (Medical aid cost too high)
- ☐ High Excess Fees/Co-Payments

Resignation/Retrenchment Date D D M M Y Y Would you like to continue your membership with NMC? (Employer group member) Yes No

G. BANK ACCOUNT DETAILS

ELECTRONIC FUND TRANSFER ☐ OR DEBIT CARD ☐

Account Holder's Name

Account No.

Bank | Type of Account: Current ☐ Savings ☐

Branch Name | Branch Code

ID/Passport No. | Date of First Deduction D D M M Y Y

I authorise Namibia Medical Care to draw from my 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 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 Medic Care of any change in respect of my address or bank.

Name _____ Account Holder's Signature _____ Date D D M M Y Y

H. UNDERTAKING BY THE APPLICANT

1. 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 the 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 events 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 in which event all monies 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.

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, also 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 by me to Namibia Medical Care.

Signed at _____ on the _____ Day of _____ 20 _____

Witness _____ Date _____ Applicant's Signature _____

Approval by Company _____ Date _____

(Company Official's Signature)

COMPANY STAMP