We're about you

Declaration of health Confidential

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PO Box 23064, Windhoek, Namibia
Reg No: MOHSS 003

Please note *To be completed by a registered healthcare provider. **All** questions below must be answered with a **yes or no**. If yes, please provide further detail in the appropriate spaces.*

Particulars of principal member (must be completed)

Title | Initials | First name(s)

Surname

Tel (H) | Tel (W)

Cell | Fax

Email

Principal member and dependent(s) declaration of health

Your declaration herein below, as confirmed by your registered medical practitioner (in the event of private members) or yourself (in the event of joining as part of an employer group within 3 months after becoming eligible for membership), is accepted by NHP in good faith and is material to your admission as a member and must be answered truthfully and with full disclosure of any relevant conditions.

Failure to disclose any conditions, whether intentionally or unintentionally, which manifested or originated from the causes prior to admission as a member, or within 120 days from the date of such admission ("the underwriting review period"), will at the sole discretion of the NHP, be met with the following consequences:

1. *If NHP, in its sole discretion believes any condition for which benefits claimed during the underwriting period, may have existed or originated before commencement of membership, benefits will be on hold until submission of such proof.*
2. *If the member cannot prove beyond reasonable doubt that such medical condition was not present at the time of commencement of membership, then NHP, at its sole discretion, reserves the right to withhold benefits relating to the treatment required.*
3. *NHP may exclude or limit any benefits in respect of the undisclosed condition and/or NHP may unilaterally terminate membership.*

Have you or your dependent(s) sought advice, been diagnosed with, been treated for; or suspect that they might have had a problem related to any of the following conditions/disorders in the past 12 months?

1.	Any cardiac conditions e.g. Chest pain/angina, heart attack, heart murmur, cardiac failure, palpitations, bypass, high blood pressure (hypertension) etc.	☐ Yes	☐ No
1.1.	Has your father, brother or son had coronary heart disease or stroke before age 55 years?	☐ Yes	☐ No
1.2.	Has your mother, sister or daughter had coronary heart disease or stroke before age 65 years?	☐ Yes	☐ No
1.3.	Have you been diagnosed with heart disease?	☐ Yes	☐ No
1.4.	Do you take medication for high blood pressure?	☐ Yes	☐ No
2.	Any cancer, malignancies, tumours and growths (please specify)	☐ Yes	☐ No
3.	Any disorder of the nervous system e.g. Epilepsy, stroke, migraine, cerebral palsy, paralysis, multiple sclerosis, narcolepsy, Parkinson's disease, Alzheimer's disease etc.	☐ Yes	☐ No

Principal member and dependent(s) declaration of health (continued)

4. Any problems/disorder of the circulatory system
e.g. Varicose veins, deep vein thrombosis (DVT), anaemia (please specify), high cholesterol etc.
☐ Yes ☐ No

5. Any blood or bleeding disorders
e.g. Hemophilia, christmas factor deficiency, platelet or any other blood clotting disease etc.
☐ Yes ☐ No

6. Any disorder of the digestive system/liver disorders
e.g. Ulcers (please specify), gastritis, piles, jaundice, hiatus hernia, colon problems, Crohn's disease, colitis, pancreas, gall bladder, gastro oesophageal reflux disease etc.
☐ Yes ☐ No

6.1. Do you ever drink alcoholic beverages?
e.g. 1 drink = 150ml of wine, 340ml of beer, 30ml of spirits.
☐ Yes ☐ No

6.2. If yes, what is your approximate intake of these beverages?
☐ Per day ☐ Per week

7. Any problem/disorder with ears, nose and throat
e.g. Deafness, ear infections, sinus, tonsillitis, allergic rhinitis, allergies etc.
☐ Yes ☐ No

8. Any problem/disorder with eyes
e.g. Defective vision, eye surgery, lens implant, cataracts, glaucoma, rentinitis pigmentosa, retinal detachment etc.
☐ Yes ☐ No

9. Any problem/disorder with teeth
e.g. Speech impairment, harelip, cleft palate, orthodontic treatment, gum/tooth disorder, abnormal bite etc.
☐ Yes ☐ No

10. Any disorders of the endocrine system
e.g. Thyroid disorder, Cushing's syndrome, Addison's disease, gland problems, pancreatic disorder/metabolic syndrome etc.
☐ Yes ☐ No

10.1. Have you or any of your direct family members been diagnosed with diabetes?
☐ Yes ☐ No

10.2. Do you take any diabetes medication?
(please specify)
☐ Yes ☐ No

11. Women's health
e.g. Endometriosis, infertility, ovarian cysts, hysterectomy, abnormal pap smear, biopsies, hormone replacement therapy etc.
☐ Yes ☐ No

12. Any disorder of the immune system
e.g. Any immunological disorder, Lupus etc.
☐ Yes ☐ No

13. Any psychological disorder
e.g. Depression (please specify type), anxiety/panic attacks, psychosis, bipolar disorders, schizophrenia, psychotherapy, alcohol or drug abuse, attention deficit disorder, bulimia etc.
☐ Yes ☐ No

14. Any disorder of the musculoskeletal system
e.g. Fractures, spinal/hip/knee condition, plegia, osteoporosis, muscular dystrophy, rheumatoid/osteo arthritis, fibromyalgia etc.
☐ Yes ☐ No

15. Any disorder of the respiratory system/lung conditions
e.g. Asthma, bronchiectasis/chronic cough, emphysema (COPD), pneumonia, cystic fibrosis, chronic bronchitis etc.
☐ Yes ☐ No

15.1. Do you or your dependants smoke?
(please specify)
☐ Yes ☐ No

16. Any disorder of the skin
e.g. Eczema, acne, dermatitis, growths, keloids, psoriasis, allergies, scleroderma, lupus etc.
☐ Yes ☐ No

17. Any urology disorder
e.g. Prostate disorder, prolapse bladder, urinary infections, kidney stones, blood in urine etc.
☐ Yes ☐ No

18. Any infectious/tropical disease
e.g. Bilharzia, malaria, tuberculosis (TB), hepatitis, sexually transmitted disease etc.
☐ Yes ☐ No

19. Are you or your dependents currently on any medication?
If yes, please complete the chronic medicine application form for any qualifying chronic conditions. You can download the form from our website, www.nhp.com.na.
☐ Yes ☐ No

20. Any previous operations, diagnoses, conditions, diseases, problems, treatment, investigations and tests not mentioned?
☐ Yes ☐ No

20.1. Any other disease, injury or disorder which necessitated treatment or bed rest for more than 6 days or prevented you from practising your occupation for more than a month in the past 3 years?
☐ Yes ☐ No

20.2. Have you taken any drugs like mandrax, dagga etc. during the past 5 years?
☐ Yes ☐ No

21. Any future operations, treatment, investigations and tests anticipated not mentioned?
(within the next 12 months)
☐ Yes ☐ No

Principal member and dependent(s) declaration of health (continued)

22. Women only

22.1. Are you or any of your dependants pregnant or suspect that you are pregnant? ☐ Yes ☐ No
(pregnancy test will be required)

22.2. If yes, how many weeks? ☐ Weeks

22.3. If yes, are you carrying more than one child? ☐ Yes ☐ No
e.g. Twins, triplets etc.

		Principal member	Dependant
23.	Has your mass changed (gain or loss) by more than 5kg during the past year? *(please specify)*	☐ Yes	☐ No
23.1.	Height *(without shoes)*	☐ cm	
23.2.	Weight *(without shoes)*	☐ kg	
23.3.	Waist measurement *(circumference)*	☐ cm	
23.4.	Hip measurement *(circumference)*	☐ cm	

If you/your doctor have answered 'yes' to any of the above questions please complete the details below in full. If more space is needed, please attach list. If you are HIV positive, please contact our AfA Programme upon approval of your application.

No	Detail

Doctor acknowledgment and declaration

Title ☐ Initials ☐ First name(s) ☐

Surname ☐

Practice number ☐

Tel (W) ☐☐☐☐ ☐☐☐☐☐☐☐ Fax ☐☐☐☐ ☐☐☐☐☐☐☐

Email ☐

How many months/years has he/she been your patient? ☐

*I (the doctor),_____, herewith confirm that I have examin**ed the patient/fam**ily and that all the information contained in the declaration of health is a true reflection **of the patient/famil**y's health status based on the information disclosed to myself **by the patient/fam**ily.*

_____
Signature of doctor

D D M M 2 0 Y Y
Date

Practice stamp

Section 7 Chronic medication

Please note *If you, or any of your dependants, have been prescribed chronic medication, an application form for chronic medication must be filled out and sent via fax, to 061 223 904 or email info@nhp.com.na. Please contact the call centre, tel 061 285 5400 or download the form from www.nhp.com.na.*

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

Name of dependant	Name of condition	Name of medication	Period of medication used From	to
			D D M M Y Y Y Y	D D M M Y Y Y Y
			D D M M Y Y Y Y	D D M M Y Y Y Y
			D D M M Y Y Y Y	D D M M Y Y Y Y
			D D M M Y Y Y Y	D D M M Y Y Y Y
			D D M M Y Y Y Y	D D M M Y Y Y Y
			D D M M Y Y Y Y	D D M M Y Y Y Y
			D D M M Y Y Y Y	D D M M Y Y Y Y

Please note *The Fund reserves the right to impose waiting periods, i.e. a general waiting period of 3 months and/or a condition specific waiting period of 12 months for a pre-existing condition and/or late joiner penalties, as defined in the rules of the Fund.*

Signed at _____ *on this* _____ *day of* _____ *20* _____

_____ _____

Signature of principal member *Signature of witness*