We're about you

Ex-Gratia Application

Confidential

tel 061-285-5400
email exgratia@care.nhp.com.na
website www.nhp.com.na

Office 29, First Floor Hilltop Village Mall
Ombika Street, Kleine Kuppe
P.O. Box 23064, Windhoek, Namibia

Reg No: MOHSS 0003

Please note:

Please complete in print block letters and email with supporting documentation to exgratia@care.nhp.com.na
Members or their dependants who have medical expenses that fall outside the benefits provided in the Rules of the Fund, and who require financial assistance for such due to financial hardship, may apply to the NHP Board for financial assistance.

The overarching principles applied to evaluate ex-gratia applications are:

1. *clinical necessity;*
2. *financial hardship and;*
3. *cost benefit to the member and the Fund.*

Each application is carefully evaluated on its own merits, taking into consideration, amongst others, the following factors:

- *Whether the request is specifically excluded by the Fund Rules.*
- *Whether the request was previously submitted, and / or declined and whether it is a resubmission with new information.*
- *Whether the treatment associated with the request is clinically necessary, and its impact on beneficiaries' health and finances.*
- *A full motivation and clinical reports by doctors / specialists or other relevant professionals is mandatory. Where applicable, such motivations must include photographic / radiological, pathological or related information including complete quotation(s) for the amounts requested. The clinical motivation must include the details of the condition and its clinical, financial and lifestyle impact, i.e. current and future treatment costs, prognosis and treatment goals.*
- *The balance of the member's benefits / funds available for the remainder of the year.*
- *Duration of NHP membership.*
- *Financial hardship of the member / dependant.*
- *Equity, consistency and fairness towards all members of the Fund.*

Applications are reviewed and evaluated by a medical advisory team and the Ex-Gratia Committee, comprised of members of the Board of Trustees. The Board of Trustees, in its absolute discretion, will only approve applications if satisfied that the member would otherwise suffer undue financial hardship. The deliberations and decisions of the Committee are confidential and cannot be disclosed outside that forum.

All ex-gratia considerations and allocations:

- *are discretionary in nature;*
- *may be granted / rejected at the sole discretion of the Board of Trustees;*
- *if approved, are considered to be provided over and above normal benefits as stipulated in the Fund Rules;*
- *if approved, MUST be used within 12 months from approved date, or according to an applicable treatment schedule, unless determined otherwise by the Board of Trustees.*

Ex-gratia applications need to include:

- *the accurate and comprehensive completion of this application form in full, i.e. all information required must be provided in the spaces below. Any information not completed in detail may result in the application being returned;*
- *ensuring that all necessary documentation is legible and included with the application form;*
- *ensuring that any additional information requested in the ex-gratia application vetting process is submitted within a maximum of 5 working days after being requested;*
- *receipts for any payments to providers already paid by a beneficiary.*

Please note that:

- *Incomplete documentation may result in the application not being processed timeously.*
- *Neither NHP, nor the administrator will source outstanding information (e.g. financial statements from banks, clinical reports or quotations from health care providers etc.) from third parties on behalf of the member.*
- *Submission of all documentation required for the ex-gratia application, including any additional information identified in the vetting process, is the responsibility of the member.*
- *Any clinical or financial misinformation or misrepresentation provided in this application may be considered an inappropriate petition to NHP, and may result in the rejection of the application or further sanction as provided for in the Rules. This includes, but is not limited to, false, misleading or incomplete information related to income, expenses, or any other clinical or financial details.*

Particulars of principal member

Membership number | Benefit option

Membership commencement date (DD / MM / YYYY)

Title | Initials | First names

Surname | Age

Tel home | Tel work

Cell no | Fax no

Email (mandatory for future correspondence)

Postal address

Particulars of dependant(s) – if applicable

Relationship (to principal member)	**First name(s) in full**	**Surname** (if different from principal member)	**Gender**	**Date of birth**
			○ M ○ F	DD / MM / YYYY
			○ M ○ F	DD / MM / YYYY
			○ M ○ F	DD / MM / YYYY
			○ M ○ F	DD / MM / YYYY
			○ M ○ F	DD / MM / YYYY
			○ M ○ F	DD / MM / YYYY

Declaration by employer

Please note: *To be completed if the employer is responsible for all or part of your contribution. Employers registered as part of any umbrella body should please note that the condition for membership of such an umbrella body is that companies should renew their membership on an annual basis and provide proof of such updated subscriber status to NHP.*

Name of employer

Group pay point number | Salary payroll number

Tel home | Fax no

Employment date (DD / MM / YYYY) | Eligible start date (DD / MM / YYYY)

Employer acknowledgement and declaration

We confirm that the applicant is employed by us and became / will become eligible for membership on the above date. Contributions are being deducted according to the Fund rules and benefit option chosen. All sections of the application form have been completed.

Name of company official

Signature of company official

Company stamp

Details of the ex-gratia request

Have you previously applied for ex-gratia?	*yes*	*no*
Is this an appeal to a previously declined ex-gratia application?	*yes*	*no*
Are you claiming from an insurer or a third party other than NHP?	*yes*	*no*
Are your benefits exceeded?	*yes*	*no*
Is treatment not covered by NHP?	*yes*	*no*
Is your claim submitted more than 4 months after the date of service?	*yes*	*no*

If yes to any of these questions, please provide details below

Reason for ex-gratia request

Please explain why you are applying for an ex-gratia consideration

Beneficiary details to be completed by the member

Please note: *Please complete one column per beneficiary if applying for more than one person.*

Beneficiary A		Beneficiary B	
First names		First names	
Surname		Surname	
Title		Title	
Gender	F M	Gender	F M
Date of birth	DD / MM / YYYY	Date of birth	DD / MM / YYYY
Occupation		Occupation	
Commencement date	DD / MM / YYYY	Commencement date	DD / MM / YYYY
Tel home		Tel home	
Tel work		Tel work	
Cell no		Cell no	
Fax no		Fax no	
Email		Email	

Details of the request and costs involved

Please provide details of what specifically you are requesting for ex-gratia, including actual costs involved (N$ value). Approximate figures are not acceptable. Please attach all quotations, invoices and treatment plans from medical providers, e.g. doctors, hospitals, etc.

Beneficiary A	Beneficiary B

Medical report (to be completed by doctor / medical provider)

Please note: *Please attach a detailed motivation letter and, where applicable, radiological and pathological reports and photographs.*

Diagnosis and ICD-10 codes

Beneficiary A

Beneficiary B

Medical history and clinical details

Beneficiary A

Beneficiary B

Detailed motivation

Please provide a detailed motivation

Beneficiary A

Beneficiary B

Treatment and medication required

Please attach detailed quotation/s.

Beneficiary A

Beneficiary B

Doctor / medical provider details, acknowledgement and declaration

Title		*Initials*		*First names*	
Surname					
Practice number					
Tel work				*Fax no*	
Email					
How many months / years has he / she been your patient?					
I (the doctor / medical provider)					

herewith confirm that I have examined the patient / family and that all the information contained in the declaration of health is a true reflection of the patient / family's health status based on the information clinically apparent and / or disclosed to myself by the patient / family.

Signature of doctor / medical provider		*Date*	*DD / MM / YYYY*

Practice stamp

Statement of income and expenditure (to be completed by member)

		Member		***Spouse / partner***		***Total***
Gross monthly income	*N$*		*N$*		*N$*	
Total deductions	*N$*		*N$*		*N$*	
Total net income	*N$*		*N$*		*N$*	

Monthly expenditure

Fixed

Rent / bond	*N$*	
Maintenance of ex-spouse	*N$*	
Bank loans	*N$*	
Staff	*N$*	
Study	*N$*	

Variable

Groceries and toiletries	*N$*	
Wages	*N$*	
Water and electricity	*N$*	
Rates and taxes	*N$*	
Telephone: Home	*N$*	

Hire purchases	*N$*		*Cell phone*	*N$*	
Insurance: Life	*N$*		*Transport*	*N$*	
Insurance: Endowment	*N$*		*Clothing*	*N$*	
Insurance: Retirement annuity	*N$*		*Entertainment*	*N$*	
Other medical	*N$*		*School: Fees*	*N$*	
Homeowner levies	*N$*		*School: Transport*	*N$*	
Car	*N$*		*School: Sport*	*N$*	
Credit card payments	*N$*		*School: Tuck*	*N$*	
Other	*N$*		*Other*	*N$*	
Total fixed expenses	*N$*		***Total variable expenses***	*N$*	

Monthly provision for annual payments

TV licence	*N$*	
Car licence	*N$*	
Income tax	*N$*	
Other	*N$*	
Total monthly provision	*N$*	

Possible monthly payments

Gifts	*N$*	
Newspaper	*N$*	
Other	*N$*	
Total monthly possibilities	*N$*	

Summary of income and expenditure

Net monthly income	*N$*		*Total expenditure*	*N$*	
Net deficit / surplus *(income less expenditure)*	*N$*				

Statement of assets and liabilities (to be completed by member)

Assets	*Value*		*Liabilities*	*Value*	
Residential property owned	*N$*		*Mortgage bonds*	*N$*	
Other properties owned	*N$*		*Bank overdraft*	*N$*	
Shares, investments and savings	*N$*		*Loans*	*N$*	
Debtors and loans: cash in the bank	*N$*		*Creditors*	*N$*	

Other significant assets	*N$*		*Other significant liabilities*	*N$*	
Total	*N$*		***Total***	*N$*	

Check list – please tick all boxes to confirm

Please note: *We cannot process your application if it is incomplete, incorrect, or if you have not attached the correct documents. Please use this check list to make sure that you are sending us a copy of everything we need.*

- ☐ *Medical report – full details including treatment costing*
- ☐ *Proof of income – copies of your last three months' salary slip / pension and bank statements, and any other sources of income for both principal member and spouse / partner.*
- ☐ *If you are a business owner – a copy of your latest audited financials*

Particulars for ex-gratia gratuity (if approved)

☐ *Pay member (provide receipts)* ☐ *Pay provider* *Please specify*

Acknowledgement and declaration

I, the undersigned, hereby certify that the information furnished by me in this application is complete, true and correct. I authorise my doctor / medical provider to disclose information to NHP, provided such information is treated as confidential at all times.

Signature of principal member *Date* *DD / MM / YYYY*