We're about you

Ex-Gratia request Confidential

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

Please note *In order for the administrator to deliver efficient service to you, it is important that you provide and complete all information as required. Print clearly using **capital** letters. Only **one** character per block. Leave open **one** block between words. Mark with an **X** where necessary.*

Prerequisites for completion and processing

1. *The application form must be completed in full, i.e. all information required must be provided. Please do not leave any spaces blank, or delete, without reading and providing the detail as required.*
2. *The Medical Advisory Board may make Ex-Gratia awards only if the Board of Trustees, in its absolute discretion is satisfied that the member would otherwise suffer undue financial hardship.*
3. *All claims in excess of the benefit limits must be submitted prior to the Ex-Gratia Committee, making its decision.*
4. *In the space provided below, please indicate to whom the Ex-Gratia award(s) must be paid over to; should this application be successful.*

Check list (compulsory)

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 - Including treatment costings*
- ☐ *Proof of income - A copy of your latest salary slip/pension and bank statement for both principal and spouse/partner*
- ☐ *If you are a business owner - A copy of your latest audited financials*

Particulars for payment

☐ *Pay member* ☐ *Pay supplier* *Please specify*

Particulars of principal member (must be completed)

Membership number *Date of commencement*

Title - *Initials* *First name(s)*

Surname *Age*

Tel (h) *Tel (w)*

Cell *Fax*

Email

Postal address

Particulars of Dependant(s) (if applicable)

Please note *Attach copies of ID/Passport, marriage certificates, birth certificates, legal adoption or foster care court order documents. The decision of the Board of Trustees will be final and cannot be appealed. Acceptance of the dependants will be in accordance with the Rules of the Fund.*

Relationship (To principal member)	First name(s) in full	Surname (If different from principal member)	Gender	Date of birth
			M F	
			M F	
			M F	
			M F	
			M F	
			M F	

Declaration by employer (if applicable)

Please note *To be completed if employer is responsible for all or part of your contribution. Employers registered as part of any umbrella body, should please note 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 *Fax*

Employment date *Eligible start date*

Employer acknowledgment 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

What is the nature of request?

Name of patient *Title* - *Initials* *First name(s)*

Surname

Membership commencement date *Benefit option* Select a benefit

Date of birth *Gender* M F *Occupation*

Tel (h) *Tel (w)*

Cell *Fax*

Email

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

Members' motivation for Ex-Gratia

Please note Please attach all documents relevant to the motivation of this application.

Doctors' report (to be completed by doctor)

Diagnosis

Please note Please attach detailed motivation letter and where applicable photographs.

Medical history

Treatment and medication required

Please note Please attach detailed quotation.

Doctor acknowledgment and declaration

Title Dr 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 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 disclosed to myself by **the patient/family**.

_____

Signature of doctor

Practice stamp

Date

Statement of Income and Expenditure (to be completed by member)

		Member		Spouse/Partner		Total
Gross monthly income	N$		N$		N$	0.00
Total deductions	N$		N$		N$	0.00
Total Net Income	N$	0.00	N$	0.00	N$	0.00

Monthly expenditure

Fixed

Rent/Bond	N$	
Maintenance of ex-spouse	N$	
Bank loans	N$	
Staff	N$	
Study	N$	
Hire purchases	N$	
Insurance: Life	N$	
Insurance: Endowment	N$	
Insurance: Retirement annuity	N$	
Other medical	N$	
Homeowner Levies	N$	
Car	N$	
Credit card payments	N$	
Other	N$	
Total Fixed Expenses	**N$**	0.00

Variable

Groceries and toiletries	N$	
Wages	N$	
Water and electricity	N$	
Rates and taxes	N$	
Telephone: Home	N$	
Cell phone	N$	
Transport	N$	
Clothing	N$	
Entertainment	N$	
School: Fees	N$	
School: Transport	N$	
School: Sport	N$	
School: Tuck	N$	
Other	N$	
Total Variable Expenses	**N$**	0.00

Monthly provision for annual payments

TV license	N$	
Car license	N$	
Income tax	N$	
Other	N$	
Total Monthly Provision	**N$**	0.00

Possible monthly payments

Gifts	N$	
Newspaper	N$	
Other	N$	
Other	N$	
Total Monthly Possibilities	**N$**	0.00

Summary of income and expenditure

Monthly income

Net Monthly Income	**N$**	0.00
Net Deficit / Surplus (Income less Expenditure)	**N$**	0.00

Monthly expenditure

Total Expenditure	**N$**	0.00

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$**	0	**Total**	**N$**	0

Acknowledgment 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 to disclose information to NHP, provided such information is treated as confidential at all times.

Signature of principal member

Date