We're about you

Ex-Gratia Application
Confidential

tel 061 285 5400
email exgratia@nhp.com.na
www.nhp.com.na
Reg No: MOHSS 003

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.

Please note that 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;
- ensure that all necessary documentation is legible and included with the application form;
- ensure that any additional information requested in the ex-gratia application vetting process is submitted within a maximum of 5 working days after requested;
- Any payments to providers already paid by a beneficiary must include receipts.

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 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 D D M M Y Y Y Y

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

Relationships (to principal member)	First name(s) in full	Surname (If different from principal member)	Gender	Date of Birth
			M F	D D M M Y Y Y Y
			M F	D D M M Y Y Y Y
			M F	D D M M Y Y Y Y
			M F	D D M M Y Y Y Y
			M F	D D M M Y Y Y Y
			M F	D D M M Y Y Y Y

Declaration by employer

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 home | Fax no.

Employment date D D M M Y Y Y Y | Eligible start date D D M M Y Y Y Y

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

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

Applicable Beneficiaries details to be completed by the member

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

Beneficiary A

First Names

Surname Title

Gender male ☐ female ☐ Date of Birth D D M M Y Y Y Y

Occupation

Membership commencement date D D M M Y Y Y Y

Tel home Tel work

Cell no. Fax no.

Email

Beneficiary B

First Names

Surname Title

Gender male ☐ female ☐ Date of Birth D D M M Y Y Y Y

Occupation

Membership commencement date D D M M Y Y Y Y

Tel home Tel work

Cell no. Fax no.

Email

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 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

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

D D M M Y Y Y Y

Date

Company 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$ _____
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$ _____

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$ _____

Monthly provision for annual payments

TV license	N$ _____
Car license	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

Monthly income

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

Monthly expenditure

Total 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 _____

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 / medical provider to disclose information to NHP, provided such information is treated as confidential at all times.

_____ D D M M Y Y Y Y

Signature of principal member Date