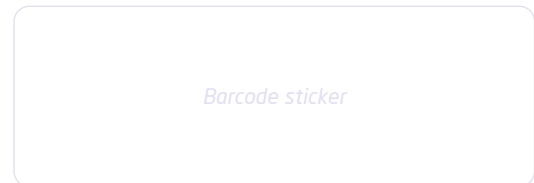




We're about you

# Membership application form Confidential

tel 061 285 5400  
fax 061 230 465  
email members@nhp.com.na  
website www.nhp.com.na  
Erf 1319 Grove Street  
Kleine Kuppe, Windhoek  
PO Box 23064, Windhoek, Namibia  
Reg No: MOHSS 003



## For office use only

### Membership

|                              |                                   |                                       |                                   |                                 |                                 |
|------------------------------|-----------------------------------|---------------------------------------|-----------------------------------|---------------------------------|---------------------------------|
| Membership number            | <input type="text"/>              |                                       |                                   | Date of commencement            | <input type="text"/>            |
| Benefit option               | <input type="checkbox"/> Gold     | <input type="checkbox"/> Platinum     | <input type="checkbox"/> Titanium | <input type="checkbox"/> Bronze | <input type="checkbox"/> Silver |
|                              | <input type="checkbox"/> Hospital | <input type="checkbox"/> Blue Diamond | <input type="checkbox"/> Litunga  |                                 |                                 |
| Principal member             | Title <input type="text"/>        | Initials <input type="text"/>         | First name(s)                     | <input type="text"/>            |                                 |
| Group number (if applicable) | <input type="text"/>              |                                       |                                   |                                 |                                 |

### Clinical and underwriting

|                                   |   |                                   |  |  |  |
|-----------------------------------|---|-----------------------------------|--|--|--|
| <input type="checkbox"/> Accepted | <input type="checkbox"/> Rejected           |                                   |  |  |  |
| General waiting period            | <input type="checkbox"/> 3 month            | <input type="checkbox"/> 12 month | <input type="checkbox"/> No waiting period |  |  |
| Condition specific waiting period | <input type="checkbox"/> 12 month maternity |                                   |  |  |  |
| Underwriting decision             | <input type="text"/>                        |                                   |  |  |  |
| <input type="text"/>              |   |                                   |  |  |  |
| Comments                          | <input type="text"/>                        |                                   |  |  |  |
| <input type="text"/>              |   |                                   |  |  |  |
| <input type="text"/>              |   |                                   |  |  |  |
| <input type="text"/>              |   |                                   |  |  |  |

|           |                      |             |                      |                 |                      |
|-----------|----------------------|-------------|----------------------|-----------------|----------------------|
| Loaded by | <input type="text"/> | Approved by | <input type="text"/> | Control Officer | <input type="text"/> |
| Date      | <input type="text"/> | Date        | <input type="text"/> | Date            | <input type="text"/> |

## Prerequisites for completion and processing

**Please note** In order for the administrator to deliver efficient service to you, it is imperative that all sections of this application form to be completed in full. Failing this may cause delay in the processing of the application.

**Potential members of NHP are recommended not to resign from their present medical aid fund before they have officially been informed that their application has been approved. Submission of this application form and any further requested documents does not guarantee approval of membership.**

1. Print clearly using **capital** letters. Only **one** character per block. Leave open **one** block between words. Mark with an **X** where necessary. All sections must be completed.
2. The application form must be completed truthfully and in full, and with full disclosure. Please do not leave any spaces blank, or delete, without reading and providing the detail as required. NHP accepts the information in good faith and is material to your admission as a member i.e. all information with full disclosure required must be provided.
3. The required date of membership must be stated in writing on this form. This date can only be from the 1st day of the present calendar month, or future date, but no more than 3 months in advance.
4. Indicate which benefit option you are choosing.
5. Indicate your preference for access to accumulated Roll-Over benefit, should you qualify.
6. Your full personal details are essential for our records, thus please provide in full, as well as your occupation.
7. The particulars of your present, as well as your previous medical aid fund membership are essential in order to determine your underwriting risks and insurability.
8. Attach copies of ID/Passport(s), marriage certificate, birth certificate(s), legal adoption or foster care court order documents.
9. Complete the declaration of health truthfully and with full disclosure of any relevant condition(s).

**Failure to disclose pre-existing conditions could limit and/or exclude you from receiving certain benefits or result in the termination of your membership.**

## Your check list

**Please note** In order to avoid delays in processing your application, please use this checklist to make sure that you have attached a copy of everything we need.

|   |   |  |
|---|---|--|
| <input type="checkbox"/> ID/Passport of principal member  | <input type="checkbox"/> Marriage certificate (if applicable)           | <input type="checkbox"/> ID/Passport of spouse |
| <input type="checkbox"/> Full birth certificate(s) of children  | <input type="checkbox"/> Previous medical aid(s) membership certificate | <input type="checkbox"/> Doctor's certificate  |
| <input type="checkbox"/> Copy of the bank statement/cancelled cheque/letter from the bank/bank letterhead confirming the account holder's details |   |  |

## Section 1 Particulars of principal member (must be completed)

Title  Initials  First name(s)

Surname

Marital status  Single  Married  Divorced  Widowed Other

Pensioner  Yes  No

Nationality of passport  ID/Passport number

Date of birth         Gender  M  F Occupation

Tel (H)         Tel (W)

Cell         Fax

Email

Postal address  Postal code

Physical address

## Section 2 Previous medical aid details

**Please note** Attach a copy of previous medical aid fund certificate of membership, covering the last 24 months. Should you need additional space to provide the necessary information. Please make a copy of this section and attach to the application form. It is important that you specify exact membership join and termination dates for each medical aid fund.

Have you or your dependent(s) been a member of NHP in the past?  Yes  No

Membership number  Status  Principal member  Dependant

Have you or any of your dependent(s) had previous medical aid cover?  Yes  No

Membership number (if applicable)  Status  Principal member  Dependant

| Name of medical aid  | Name of member       | Membership number    | Date joined   | Date terminated   |
|----------------------|----------------------|----------------------|---|---|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |

## Section 2 Previous medical aid details (continued)

Are you changing your medical aid fund due to a change in your employment? If yes, please provide a letter from employer confirming new employment.

Yes  No

Have any condition specific waiting periods, exclusions or late-joiner penalties ever been imposed by previous medical aid fund(s)?

Yes  No

## Section 3 Benefit options

**Please note** The benefit option selected includes the following inclusive benefits of which the risk is fully underwritten by a registered insurer, as required by the Medical Aid and Insurance Acts: Emergency benefit, repatriation benefit, international travel benefit as well as premium waiver.

|                       |  |   |   |
|-----------------------|--|---|---|
| Status of applicant   | <input type="checkbox"/> Private member    | <input type="checkbox"/> Member of employer group |   |
|                       | <input type="checkbox"/> Continuous member | Membership number                                 | <input type="text"/>  |
| Benefit option choice | <input type="checkbox"/> Gold              | <input type="checkbox"/> Platinum                 | <input type="checkbox"/> Titanium   |
|                       | <input type="checkbox"/> Bronze            | <input type="checkbox"/> Silver                   | <input type="checkbox"/> Hospital   |
|                       | <input type="checkbox"/> Blue Diamond*     | <input type="checkbox"/> Litunga*                 |   |
|                       | Roll-Over benefit (once accumulated)       | <input type="checkbox"/> Automated                | <input type="checkbox"/> Manual   |
| Monthly contribution  | N\$ <input type="text"/>                   | I wish to join NHP from                           | <input type="text"/> 0 <input type="text"/> 1 <input type="text"/> M <input type="text"/> M <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> Y <input type="text"/> Y |

\* For a full list of our Designated Service Providers, please contact one of our branches or visit [www.nhp.com.na](http://www.nhp.com.na)

## Section 4 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         | <input type="text"/>  |                          |   |
| Group pay point number   | <input type="text"/>  | Salary payroll number    | <input type="text"/>  |
| Tel                      | <input type="text"/>  | Fax                      | <input type="text"/>  |
| Employment date          | <input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y | Eligible start date      | <input type="text"/> 0 <input type="text"/> 1 <input type="text"/> M <input type="text"/> M <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> Y <input type="text"/> Y |
| <b>Principal member</b>  | <b>Adult/Spec dependant</b>   | <b>Child dependant</b>   | <b>Total</b>  |
| N\$ <input type="text"/> | N\$ <input type="text"/>  | N\$ <input type="text"/> | N\$ <input type="text"/>  |

## 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



## Section 5 Dependant(s) you wish to register

**Please note** Please 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<br>(To principal member) | First name(s) in full | Surname<br>(If different from principal member) | Gender  | Date of birth  |
|---------------------------------------|-----------------------|---|---|--|
| <input type="text"/>                  | <input type="text"/>  | <input type="text"/>                            | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="text"/>                  | <input type="text"/>  | <input type="text"/>                            | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="text"/>                  | <input type="text"/>  | <input type="text"/>                            | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="text"/>                  | <input type="text"/>  | <input type="text"/>                            | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="text"/>                  | <input type="text"/>  | <input type="text"/>                            | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="text"/>                  | <input type="text"/>  | <input type="text"/>                            | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |

## Section 6 Principal member and dependent(s) declaration of health

**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.

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<br>e.g. Chest pain/angina, heart attack, heart murmur, cardiac failure, palpitations, bypass, high blood pressure (hypertension) etc.  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 1.1. Has your father, brother or son had coronary heart disease or stroke before age 55 years?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 1.2. Has your mother, sister or daughter had coronary heart disease or stroke before age 65 years?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 1.3. Have you been diagnosed with heart disease?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 1.4. Do you take medication for high blood pressure?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Any cancer, malignancies, tumours and growths<br>(please specify)   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Any disorder of the nervous system<br>e.g. Epilepsy, stroke, migraine, cerebral palsy, paralysis, multiple sclerosis, narcolepsy, Parkinson's disease, Alzheimer's disease etc.   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Any problems/disorder of the circulatory system<br>e.g. Varicose veins, deep vein thrombosis (DVT), anaemia (please specify), high cholesterol etc.   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Any blood or bleeding disorders<br>e.g. Hemophilia, christmas factor deficiency, platelet or any other blood clotting disease etc.  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Any disorder of the digestive system/liver disorders<br>e.g. Ulcers (please specify), gastritis, piles, jaundice, hiatus hernia, colon problems, Crohn's disease, colitis, pancreas, gall bladder, gastro oesophageal reflux disease etc. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6.1. Do you ever drink alcoholic beverages?<br>e.g. 1 drink = 150ml of wine, 340ml of beer, 30ml of spirits.   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Doctor's initial(s)



## Section 6 Principal member and dependent(s) declaration of health (continued)

- 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, retinitis pigmentosa, retinal detachment etc.  Yes  No
9. Any problem/disorder with teeth  
e.g. Speech impairment, harellip, 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](http://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

Doctor's initial(s)





## 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](mailto:info@nhp.com.na). Please contact the call centre, tel 061 285 5400 or download the form from [www.nhp.com.na](http://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                   |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/>      | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/>      | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/>      | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/>      | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/>      | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/>      | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/>      | <input type="text"/> |

**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.

## Section 8 Refund of claim payments/debit order instruction

**Please note** If the below banking details are not correct, the Fund will not be able to settle your claims. This is a condition of membership stipulated in the rules of the Fund. It should be noted that this is not a debit order mandate. NHP will not be responsible in any way for the amounts refunded once claims have been refunded into the bank account you have chosen.

**Please provide the following documents:**

1. If account holder differs from that of principal member, an affidavit is required.
2. Copy of the account holder's ID.
3. Copy of the bank statement/letter from the bank/bank letterhead confirming the account holder's details.
4. Account holder's signature.

### Banking details

Use this bank account for  and/or

|                        |                      |                      |          |                      |                      |                      |
|------------------------|----------------------|----------------------|----------|----------------------|----------------------|----------------------|
| Name of account holder | Title                | <input type="text"/> | Initials | <input type="text"/> | First name(s)        | <input type="text"/> |
| Surname                | <input type="text"/> |                      |          |                      |                      |                      |
| Bank                   | <input type="text"/> |                      |          | Branch               | <input type="text"/> |                      |
| Branch code            | <input type="text"/> |                      |          | Type of account      | <input type="text"/> |                      |
| Account number         | <input type="text"/> |                      |          |                      |                      |                      |

### Account holder acknowledgment and declaration

I instruct the administrator to electronically collect contributions and to deposit claim refunds, via the Electropay system, using the information provided above. I understand that transfers cannot be done to and from credit card accounts. I also irrevocably authorise the administrator to adjust any incorrect transactions and/or correct any electronic transfer of fund errors without prior notice. No post office savings accounts are allowed.

I further authorise NHP to increase the amounts due, in terms of the policy, from time to time and authorise my bank/building society to effect payment of such increased amount upon receipt of a written notice from NHP 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 30 days written notice to NHP.

I agree that I am not entitled to recover any amount drawn from my account should my bank/building society repay such amount to me, I will refund it to NHP immediately. I undertake to notify NHP of any changes in respect of my address or bank/building society.

\_\_\_\_\_

Signature of account holder

Date



## Section 9 Member acknowledgment and declaration

1. I warrant that the information I have provided pertaining to me and my dependants is true and accurate, specifically the disclosures regarding my medical condition, and I acknowledge that NHP relies implicitly on the completeness and truthfulness thereof. Should there be any non-disclosure or material misrepresentation, I understand that my membership may be terminated and that I may forfeit my contributions to NHP. NHP reserves the right to claim damages in respect of any loss or damages it may suffer due to my non-disclosure or misrepresentation.
2. Should any of mine or my dependant(s) circumstances alter subsequent to the date of filling in this application, prior to or after the acceptance of my membership by NHP, I shall promptly notify NHP of the change. I acknowledge that failure to do so may lead to the termination or amendment of the terms and conditions of my membership, and NHP shall also be entitled to reclaim any amounts it may have erroneously paid to any medical professional on my behalf or my dependant(s) behalf.
3. I authorise and instruct my employer to deduct and pay over any amounts (that may become due and owing on my behalf) to NHP from time to time and I also authorise any persons, bodies or institutions who may hold retirement funds for my benefit, to deduct and pay to NHP all amounts that may become due and owing to NHP from time to time. I agree that should NHP incur any legal costs or expense to recover any contributions, I shall be responsible for such costs and expenses on the attorney/client scale.
4. Notwithstanding the above, I understand that it is my responsibility as a member to ensure that the monthly contributions are received by NHP.
5. Should any contributions be unpaid, it may result in me and my dependant(s) being suspended from NHP until all arrear contributions have been settled. Should 2 months' contributions be outstanding, NHP shall have the right to immediately cancel my NHP membership. I also understand that should my membership be suspended or terminated, I shall not be entitled to any benefits arising from my membership whatsoever.
6. I shall inform the Fund regarding any changes to my dependant(s) health or personal status, as required by the Fund rules, within 30 days of the change in circumstances.
7. I authorise my doctor to disclose information to the Fund, provided such information is treated as confidential at all times.
8. I agree to provide NHP with any medical or historical information or grant NHP access to medical information reasonably requested pertaining to a particular ailment, disease, disorder, condition or disability.
9. I agree that should I be accepted as a member of NHP, I shall provide NHP with all information including medical information that NHP may reasonably require for the purpose of carrying out its obligations in terms of the Medical Aid Funds Act, 1995 (Act 23 of 1995) and the rules of the Fund.
10. I declare that I and my dependant(s) are not beneficiaries of another registered medical aid fund.
11. I authorise and permit NHP to take all reasonable steps to verify information provided by me in this application form.
12. I warrant that the information provided is true and accurate and should my application be accepted by NHP, the contents of this application form shall constitute the basis of my agreement with NHP.
13. As a paying member, I acknowledge that monthly contributions are payable in advance in accordance with the rules of the Fund and shall be paid on or before the 7th day of each calendar month.
14. I hereby consent that all contact details given in this application form and any amendments to those contact details may be used by NHP or any appointed agent of NHP for sending any information of any nature (confidential or other).
15. I, the undersigned, hereby acknowledge that I have read and understood the rules of the Fund and consent of my own free will. I herewith undertake to adhere to the rules of the Fund at all times.
16. I declare that all information provided on this form, to the best of my knowledge is true and accurate, specifically the disclosures regarding the declaration of health. I acknowledge that NHP relies implicitly on the completeness and truthfulness thereof. Should my application be accepted by NHP, the contents of this application shall constitute part of the terms of my agreement with NHP.
17. I acknowledge that should I wish to terminate my membership to the fund I am obliged to give one calendar month notice of termination and shall remain liable for contributions during this period.

Signed at \_\_\_\_\_ on this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_

\_\_\_\_\_  
Signature of principal member

\_\_\_\_\_  
Signature of witness

