Pharmacy Care
Corporate Healthcare Solution

nhp™
We're about you

tel 061 285 5400
email members@nhp.com.na
website www.nhp.com.na
Unit 2, Demushuwa Suites, C/o of Grove & Ombika Sts
Kleine Kuppe, Windhoek
PO Box 23064, Windhoek, Namibia
Reg No: MOHSS 003

PharmacyCare dependant registration form

Barcode sticker

For office use only

Membership

Membership number _____ Date of commencement D D M M 2 0 Y Y

Principal member Title _____ Initials _____ First name(s) _____

Group number (if applicable) _____

☐ Accepted ☐ Rejected

Comments _____

Loaded by _____ Approved by _____ Control Officer _____

Date D D M M 2 0 Y Y Date D D M M 2 0 Y Y Date D D M M 2 0 Y Y

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. Your full personal details are essential for our records, thus please provide in full, as well as your occupation.
6. Attach copies of ID/Passport(s), marriage certificate, birth certificate(s), legal adoption or foster care court order documents.

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.

- ☐ Proof of legal adoption/foster care
- ☐ Full birth certificate(s) of children
- ☐ Marriage certificate (if applicable)
- ☐ Previous medical aid(s) membership certificate
- ☐ ID/Passport of spouse/partner

Section 1 Particulars of principal member (must be completed)

Membership number ____________ Benefit option ____________

Title ______ Initials ______ First name(s) ____________

Surname ____________

Section 2 Particulars of spouse/partner/additional adult/child dependant (a maximum of 3 dependants allowed)

Please note An adult dependant is anyone who is 21 years or older. Child rates will apply to any full-time 21 to 25 years of age student provided that proof (registration details) are attached to the application form for the current academic year. You are able to register adult or child dependants on this form. 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.

☐ Spouse ☐ Partner ☐ Additional adult ☐ Child dependant Effective date D D M M Y Y Y Y

Title ______ Initials ______ First name(s) ____________

Surname (if different from principal member) ____________

Date of birth D D M M Y Y Y Y Gender M F ID/Passport number ____________

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Cohabiting

☐ Spouse ☐ Partner ☐ Additional adult ☐ Child dependant Effective date D D M M Y Y Y Y

Title ______ Initials ______ First name(s) ____________

Surname (if different from principal member) ____________

Date of birth D D M M Y Y Y Y Gender M F ID/Passport number ____________

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Cohabiting

☐ Spouse ☐ Partner ☐ Additional adult ☐ Child dependant Effective date D D M M Y Y Y Y

Title ______ Initials ______ First name(s) ____________

Surname (if different from principal member) ____________

Date of birth D D M M Y Y Y Y Gender M F ID/Passport number ____________

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Cohabiting

Section 3 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
			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

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 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			
Group pay point number		Salary payroll number	
Tel		Fax	
Employment date	D D M M Y Y Y Y	Eligible start date	0 1 M M 2 0 Y Y

Principal member	Adult/Spec dependant	Child dependant	Total
N$	N$	N$	N$

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

Member acknowledgment and declaration

1. *I warrant that the information I have provided pertaining to me and my dependants is true and accurate, and I acknowledge that NHP relies implicitly on the completeness and truthfulness thereof. Should there be any 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) 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. 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*