Summary of Changes 2019

While you spend time with family and friends, let us take care of your medical aid needs

At NHP, we offer a range of affordable and highly competitive healthcare benefit options tailored to suit your needs. Both corporate and individual NHP clients may choose from any of these benefit options. Our products can also be tailored to suit corporate requirements.

Disclaimer

The new benefits, contributions and rules of NHP for 2019, as approved by the Fund's Board of Trustees, are subject to final approval by the Registrar of Medical Aid Funds/NAMFISA. Members are advised that the new benefits and contributions will only become effective on 1 January 2019 (and only after approval by the Registrar of Medical Aid Funds/NAMFISA), despite possible dissemination of revised information to the market before the effective date.

Should any proposed changes to benefits and contributions not be approved, members will be informed accordingly.

Errors and omissions excepted (E&OE). Whilst every care has been taken to ensure that the information in this document is correct, errors and omissions may occur and the Fund cannot be held accountable for any reliance placed on the information contained herein. The Fund's Client Services, tel 061 285 5400 may be contacted to confirm any information contained in the guide.

Administered by

Important

- Members should note that this document should be read in addition to the information contained in the Benefit Guide as well as the User Guide.
- The User Guide represents a summary of the Fund Rules. Members are provided with the User Guide only when and upon, joining the Fund. Any subsequent changes to the Fund Rules as well as changes to the Benefits and Contributions per benefit option will be announced in the Summary of Changes document. Therefore it is important for members to retain this document for future reference. For an updated copy of the User Guide please enquire with your nearest NHP branch or visit our website nhp.com.na.
- This document contains a summary of changes to the benefits and contributions as approved by the Board of Trustees and to be applicable to the rules of the Fund for 2019.
- Members are advised to refer to the User Guide and Benefit Guide as a reference tool for interpretation of Fund and Benefit Rules. Any questions should be addressed to the Fund's administrators.

The Fund will not be held liable if a member's rights are prejudiced or forfeited as a result of failure or neglect to comply with the rules of the Fund which may arise from failure or neglect to read the communications issued by the Fund in order to inform, educate and create an awareness of the changes to the rules of the Fund.

Fund average increase

An effective Fund average increase of 6.5% will apply as from 1 January 2019. This compares to a Fund average increase of 7.9% for 2018. The increase was decided on taking into account a combination of factors including an average NAMAF tariff increase of 6.65% for 2019. The contribution increase is structured to maintain the current solvency levels and to maintain a sufficient surplus margin to allow the Fund to absorb adverse experience. Benefit enhancements are restricted to an inflationary (NAMAF) level in order to ensure that the products remain competitive, yet ensuring that contribution increases remain moderate. The intention is to maintain the financial position of the Fund and to minimise the impact of adverse fluctuations in the future. The Fund remains sensitive to keeping contributions at an affordable level whilst ensuring its long-term sustainability.

The increases per benefit option may be more or less than the Fund average increase announced. The reason for different average increases per benefit option is due to the fact that each benefit option's contribution increase is based on its own unique demographic profile, claims experience, ageing profile and utilisation assumptions. Cross subsidisation between benefit options is minimised to manage the risk of each benefit option individually.

What is meant by medical aid tariff?

NAMAF is the legislated entity authorised to set benchmark tariff structures on behalf of all medical aid funds. These benchmark tariffs are commonly referred to as the "NAMAF benchmark tariff", "scale of benefits" or "medical aid tariff". The NAMAF benchmark tariffs used by medical aid funds represent a specific threshold according to which the medical aid fund is able to reimburse for healthcare treatment and services rendered to the member but in no way limits the healthcare provider to charge more or less than the benchmark tariff, subject to their preference.

As such, the Fund pays claims on behalf of its members according to the set NAMAF benchmark tariffs and if a healthcare provider charges above this tariff, the member will be held liable for the difference. Healthcare providers are thus not limited to charge according to the NAMAF benchmark tariff structure only.

Importance of using a registered healthcare provider with a valid NAMAF practice number

In order for any healthcare provider to claim from any medical aid fund both the facility and the individual provider must be registered with NAMAF. NAMAF's registration of such facility and/or individual service provider is subject to the facility having been declared fit for use by the Ministry of Health and Social Services (MoHSS), the individual practitioner has been accredited with and registered by the Health Professions Council of Namibia (HPCNA) as well as having received a certificate of Good Standing from the Ministry of Inland Revenue.

Once such criteria has been complied with, NAMAF may issue such health facility or healthcare provider with a registration and associated practice number which will allow that provider to make use of the NAMAF Benchmark Tariff codes as well as submit claims with the medical aid fund for claiming purposes.

In order to remain a registered practitioner, healthcare providers need to ensure that their practice remains in good standing with the Receiver of Revenue, they comply with operating requirements as determined by the MoHSS, remain in good standing with the HPCNA and lastly renew their annual registration with NAMAF.

Failure to adhere to any of the above may result in NAMAF resorting to a temporary suspension of practice numbers in terms of the Act on Medical Aid Funds (Act. 23 of 1995) until such time that all registration requirements have been met. Members are at risk to the extent that should they have used the services of any healthcare providers with a suspended practice number during such time, then such services are deemed not to be eligible for processing against a person's medical aid benefits.

Broad classification of existing benefit options

Traditional benefit options

The Gold, Platinum and the Titanium benefit options are best described as traditional type benefit options offering various sub-limits in respect of Day-to-Day Expenses. In addition, the per family benefit concept is very popular whereby benefits are not reserved on a per beneficiary basis, but rather enable members of the family to access the overall family benefit should he/she need it.

New Generation benefit options

The NHP Hospital, Silver and Bronze benefit options are best described as new generation type of benefit options providing pooled benefits in respect of Day-to-Day Expenses with no sub-limits in respect of the various disciplines, thereby allowing the member greater flexibility in deciding how to allocate available funds. However benefits are still allocated on a per family basis which allows that benefits are not reserved on a per beneficiary basis, but rather enable members of the family to access the overall family benefit should he/she need it.

Primary Care benefit options

The Blue Diamond and Litunga benefit options are tailored around the funding of primary healthcare services in order to make access to quality, affordable private primary healthcare more readily available for first time members as well as for potential members who would like to enjoy the benefits of subscribing to a medical aid fund but for whom affordability is of prime importance. These low-cost Primary Care benefit options offer a range of comprehensive benefits ranging from GP visits and treatment, acute and chronic medication, optical, dentistry and access to HIV/AIDS benefits. Specialist visits and consultations as well as treatment and surgical procedures in the private wing facilities of state hospitals are only available to Blue Diamond members.

Changes to benefits across various benefit options for 2019

All benefit options have received increases in-line with inflation adjusted figures and in the case of some benefits above inflationary increases.

1. Overall Annual Limit (OAL)

Benefit option	Individual member	Family
Gold	Unlimited per annum	Unlimited per annum
Platinum	Unlimited per annum	Unlimited per annum
Titanium	N$ 1,400,000 per annum	N$ 2,100,000 per annum
Silver	N$ 1,100,000 per annum	N$ 1,750,000 per annum
Bronze	N$ 500,000 per annum	N$ 800,000 per annum
Hospital	N$ 1,100,000 per annum	N$ 2,450,000 per annum

1.1 Preventative care benefit

The Preventative care benefits are available to members on the Gold, Platinum, Titanium, Silver and Bronze benefit options. This benefit is subject to the members' OAL and will not affect their available Day-to-Day benefits and limits.

The Preventative care benefit further consists of the following:

- Childhood immunisations
- Flu vaccines
- Women's health
- Sexual health
- Men's health
- Cardiac health
- Geriatric health
- General health

It should be noted that the use of these benefits does not affect the Day-to-Day benefits and limits.

1.2. Other conveyance/transport benefit for treatment in South Africa

In the event of a member being in need of a specific treatment or procedure not available in Namibia, on application, the Fund may assist in defraying some of the transportation costs to and from South Africa. To date members on the Bronze benefit option did not have access to such benefit but will qualify for such services as from 1 January 2019.

Commercial flights or approved flights will be organised by the Fund's accredited service providers. Children 18 years and younger travelling to South Africa must be accompanied by a guardian. The Fund covers 80% of the transportation costs, including flights, in respect of all visits and the guardian with the exception of the transportation costs to and from the airport.

This benefit is not available to members on the Blue Diamond and Litunga benefit options.

2. Major Medical Expenses (MME's)

2.1. Back and Neck Rehabilitation Programme

This is a new benefit applicable to members on all options (including the Blue Diamond and Litunga benefit options) and further subject to application and pre-authorisation. The benefit is intended to fund the cost of Document Based Care (DBC) conservative treatment for chronic back and neck ailments.

Access to this benefit is limited to the identification processes below:

- *Referral by the treating general practitioner or specialist of eligible members who would benefit from the DBC back and neck Programme, as opposed to surgery in the first instance and post-surgical rehabilitation.*
- *Pre-emptive identification of eligible beneficiaries.*
- *Pre-emptive identification through requests for hospital authorisation relating to surgery.*
- *Identification of eligible employee as part of Wellness Day screenings, with subsequent referral to the DBC Programme.*

The benefit makes provision for consultations by the General Practitioner and treatment by the Physiotherapist and Biokineticist.

The treatment protocol includes:

- *Initial assessment*
- *1st Cycle of treatment sessions and interim assessment by medical doctor*
- *2nd Cycle of treatment sessions and re-assessment by medical doctor*
- *Bi-monthly maintenance sessions, if approved.*

Funding of this conservative treatment is funded from the Major Medical Expense risk benefit and not from Day-to-Day, since this programme offers conservative treatment for back and neck related conditions.

2.2. Chronic Lifestyle Disease Extender benefit

This is a new benefit available as from 1 January 2019 and limited to specific ambulatory healthcare services for beneficiaries diagnosed with one or more of the following medical conditions:

- *Hypertension*
- *Hypercholesterolemia*
- *Diabetes Mellitus Type 2*

The intention is to assist high risk chronic members to remain under treatment for the period of cover in terms of each benefit year subject to being on a qualifying benefit option and being registered on the programme. Where a member may be diagnosed with more than one of the above conditions, the allowable services for multiple conditions shall be determined by combining the services for each disease. The quantity limits will, however, remain as the number approved for each individual disease.

The treatment(s) covered by this benefit includes:

- *Additional consultation(s) by medical practitioners restricted to the prescribed frequency of treatment codes.*
- *Chronic medicines, inclusive of diabetic disposables such as syringes, needles, strips and lancets for registered patients.*
- *Additional pathology and radiology tests.*

The Chronic Lifestyle Disease Extender benefit will only be activated once all other Acute and Chronic medication benefits as well as any available accumulated Roll-Over benefits have been depleted.

The Chronic Lifestyle Disease Extender benefit is only available to members on the Gold, Platinum and Titanium benefit options. Subject to approval and furthermore registration on the Beneficiary Risk Management Programme (BMR), high risk members on the Silver and Bronze benefit options may apply for this benefit. Members on the Hospital, Blue Diamond and Litunga benefit options will not have access to this benefit.

2.3. Prosthesis and Devices Internal – Intra Ocular lenses

The benefit for Intra Ocular lenses will be paid at 100% of the NAMAF benchmark tariff and further limited to N$ 6,033 per lens when prescribed by a registered ophthalmologist. This benefit is subject to its pre-authorisation and the relevant Managed Healthcare Programme. This benefit is not available to members on the Blue Diamond and Litunga benefit options.

2.4. Appliances and External Accessories - Stoma Products

The benefit for Stoma Products is new and available as from 1 January 2019. Access to this benefit is subject to pre-authorisation and the relevant managed healthcare protocols. A benefit of N$ 30,000 per family per annum is available. All members requiring the assistance of Stoma products and registered on any of the benefit options, with the exception of the Blue Diamond and Litunga benefit options, will qualify for the benefit.

2.5. Changes to the Private Wards Limit (OAL) with effect from 1 January 2019

Benefit option	Individual member	Family
Gold	N$ 25,000	N$ 50,400
Platinum	N$ 15,700	N$ 31,700
Titanium	N$ 10,900	N$ 21,400
Silver	N$ 10,900	N$ 21,400
Bronze	N$ 5,500	N$ 11,000
Hospital	N$ 11,500	N$ 22,800
Blue Diamond	No benefit	No benefit
Litunga	No benefit	No benefit

2.6. Accommodation other than a recognised hospital or medical institution whilst undergoing treatment in South Africa

This benefit will not be paid whilst the member is in hospital. The lodger fee will be paid for the guardian in the event of children 18 years and younger. This benefit is subject to pre-authorisation and the relevant Managed Healthcare Programme. The benefit is available at a rate of N$ 750 per family, per day for accommodation other than a recognised hospital or medical facility whilst in South Africa for treatment.

As from 1 January 2019 this benefit will also be available for members on the Bronze benefit option.

Members on the Blue Diamond and Litunga benefit options will not have access to this benefit.

2.7. Accommodation other than a recognised hospital or medical institution whilst undergoing treatment in Namibia with place of residence further than 150km away from Windhoek or Swakopmund

As from 1 January 2019 this benefit will, in addition to the Gold and Platinum benefit options, be available to members on the Titanium, Silver, Hospital and Bronze benefit options. This benefit is available at a rate of N$ 750 per family, per day for accommodation other than a recognised hospital or medical facility, limited to 2 days per family per annum.

This lodger fee will only be paid if the member lives outside of a radius of 150km from Windhoek or Swakopmund and is referred to a specialist which requires that a patient needs to sleep over. This lodger fee is restricted to 2 nights per family per annum.

This benefit will not be paid whilst the member is in hospital. The lodger fee will be paid for the guardian in the event of children 18 years and younger. This benefit is subject to pre-authorisation and the relevant Managed Healthcare Programme.

Members on the Blue Diamond and Litunga options will not have access to this benefit.

2.8. Maternity Related Services and treatment – Panorama Prenatal Test

As from 1 January 2019 this benefit will be available to all members with the exception of those on the Blue Diamond and Litunga benefit options. This benefit will include the Panorama test itself as well as the required pathology tests and will be covered at 100% of the NAMAF benchmark tariff guidelines. The benefit is subject to pre-authorisation and the relevant managed care guidelines.

2.9. Changes to the Private Nursing Limit (OAL) with effect from 1 January 2019

Benefit option	Per family
Gold	N$ 67,300
Platinum	N$ 46,700
Titanium	N$ 25,400
Silver	N$ 25,400
Bronze	N$ 11,500
Hospital	N$ 21,100
Blue Diamond	No benefit
Litunga	No benefit

This benefit is subject to pre-authorisation and the relevant Managed Healthcare Programme.

2.10. Changes to the Chronic Medicine Limit (OAL) with effect from 1 January 2019

Benefit option	Principal member	Per family
Gold	N$ 29,600	N$ 59,800
Platinum	N$ 17,300	N$ 31,800
Titanium	N$ 8,180	N$ 12,900
Silver	N$ 8,180	N$ 12,900
Bronze	N$ 3,860	N$ 6,130
Blue Diamond	-	N$ 3,410
Litunga	-	N$ 2,730

3. Day-to-Day Expenses:

3.1. Changes to the Acute Medicine Limit (Day-to-Day) with effect from 1 January 2019

Benefit option	Principal member	Per additional beneficiary
Gold	N$ 9,580	N$ 5,570
Platinum	N$ 9,370	N$ 2,320
Titanium	N$ 5,220	N$ 650
Silver	N$ 14,900 Subject to pooled Day-to-Day benefit	N$ 3,100
Bronze	N$ 6,200 Subject to pooled Day-to-Day benefit	N$ 2,000
Blue Diamond	Scripts to be paid - limited to N$ 205 per claim	
Litunga	Scripts to be paid - limited to N$ 205 per claim	

3.2. Changes to the Self-Medication Limit (Day-to-Day) with effect from 1 January 2019

Benefit option	Principal member	Per additional beneficiary	Per family	Limited
Gold	N$ 1,770	N$ 445		N$ 220 Per claim
Platinum	N$ 1,540	N$ 260		N$ 220 Per claim
Titanium	N$ 1,100	N$ 215		N$ 220 Per claim
Silver	N$ 1,040	N$ 205		N$ 220 Per claim
Bronze	N$ 750	N$ 130		N$ 220 Per claim
Blue Diamond	-	-	N$ 740	N$ 210 Per claim
Litunga	No benefit	No benefit	No benefit	

3.3. Changes to the Auxiliary Services Limit (Day-to-Day) with effect from 1 January 2019

Benefit option	Principal member	Per additional beneficiary	Visits
Gold	N$ 18,700	N$ 5,510	N$ 15 Per beneficiary
Platinum	N$ 16,000	N$ 5,140	N$ 15 Per beneficiary
Titanium	N$ 11,300	N$ 660	N$ 15 Per beneficiary
Silver	N$ 14,900 Subject to pooled Day-to-Day benefit	N$ 3,100	
Bronze	N$ 6,200 Subject to pooled Day-to-Day benefit	N$ 2,000	

3.4. GP consultation fees for Blue Diamond and Litunga members

The GP consultation fees for the Blue Diamond and Litunga benefit options have been increased to N$ 340 per consultation with a N$15 visitation fee to be paid by the member.

4. Underwriting conditions for Private Members joining the Fund

The underwriting conditions for new private members joining the Fund remain unchanged in that they are subject to the following waiting periods:

- *A general 3 month waiting period in respect of all Day-to-Day and Major Medical claims. This means that private members, within their first 3 months of membership with the Fund will not be able to claim for any Day-to-Day treatment, expenses or any scheduled surgical procedures or treatment falling within the scope of Major Medical Expense claims with the exception of emergency treatment in hospital and emergency procedures performed in emergency rooms/casualty wards.*
- *The same condition will apply if the spouse or any new beneficiary joins after the 3 month window period.*
- *A 12 month condition specific waiting period for all claims related to maternity. This means that private members, within their first 12 months after joining the Fund, will not be allowed to claim for any treatment and expenses related to maternity and including delivery.*

Members resigning from an employer group may apply for individual membership with the Fund. Upon reapplying for individual membership a person must complete and submit a new membership application together with all supporting documents. Members applying within 3 months after resigning from an employer group will be exempt from normal underwriting requirements.

5. Underwriting conditions for Employer Group Members joining the Fund

All new employer group members joining the Fund will normally be exempt from waiting periods unless the member or dependants join the Fund only 3 months after the employee first becomes eligible for membership. In the event of the 3 month window period being exceeded the following waiting periods will apply:

- *A general 3 month waiting period in respect of all Day-to-Day claims and Major Medical claims. This means that such employer group members, within their first 3 months' of membership on the Fund will not be able to claim for any Day-to-Day treatment, expenses or any scheduled surgical procedures or treatment falling within the scope of Major Medical Expense claims with the exception of emergency treatment in hospital and emergency procedures performed in emergency rooms/casualty wards.*
- *The same condition will apply if the spouse or any new beneficiary joins after the 3 month window period.*
- *A 12 month condition specific waiting period for all claims related to maternity. This means that members, within their first 12 months after joining the Fund, will not be able to claim for any treatment and expenses related to maternity.*

6. General underwriting conditions and completion of the membership application

Employees and private members joining the Fund should note that any failure to disclose conditions, whether intentionally or unintentionally, which manifested or originated from the cause prior to their admission as a member, or within 120 days ("the underwriting review period") of such admission and on which NHP implicitly relies upon for the completeness and truthfulness thereof, will at the sole discretion of the Fund, be met with the following consequences:

- *If NHP, in its sole discretion believes, that any condition for which benefits claimed during the underwriting review period may have existed or originated before commencement of membership, it may withhold benefits until such satisfactory proof has been presented by the member to the contrary.*
- *If the member cannot prove beyond reasonable doubt that such medical condition was not present at the time of commencement of membership, then NHP, in its sole discretion, reserves the right to withhold benefits relating to the treatment required.*
- *NHP may exclude or limit benefits in respect of the undisclosed condition and/or NHP may unilaterally terminate such person's membership.*

Upon signing the application form members acknowledge and declare that all information provided on the application form is, to the best of their knowledge true and accurate, especially the disclosures regarding the declaration of health.

7. Repatriation benefit

Should something unexpected happen to a member or dependant member, (usually a medical emergency a long distance from where you live) the Fund will cover the costs of transporting a member or dependant member back home. The Fund will either pay the transport costs in cash or through an agreement with a preferred transport company.

For all repatriation enquiries, please contact the NHP Call Centre.

The repatriation benefit will cover the cost of repatriation in case of:

- *Emergency transportation within South Africa and Namibia whether by means of bus transport or commercial flight, where a patient is still alive after an emergency treatment.*
- *Emergency transportation within South Africa and Namibia where the patient passed away and the mortal remains are repatriated to the town of residence in Namibia.*
- *Mortal remains repatriation inclusive from the place of death in Namibia to the mortuary or nearest town within Namibian borders will be paid to a maximum of N$ 15,000 per event.*
- *The Fund will pay one commercial flight ticket or refund any fuel costs for repatriation in South Africa and Namibia after a medical emergency evacuation per annum.*
- *Repatriation of mortal remains in Namibia or South Africa is covered if a member or a dependant receives pre-authorised treatment but subsequently passes away.*

The benefit payment is subject to provision of the following documentation:

- *Valid claim form to be completed*
- *Certified copy of the death certificate of the insured*

The benefit payment is subject to provision of the following documentation:

- *Valid claim form of the Insurer.*
- *Certified copy of the death certificate of the insured.*

The repatriation component under the International travel benefit will only apply if the member passed away as a result of, or following a medical emergency in South Africa. The cost of repatriation of mortal remains will be covered by the Fund in the event of the member passing away during, or following authorised medical treatment in South Africa only.

8. Exclusions

The following amendments have been added to the list of exclusions:

- ***Alternative healthcare providers:***
  - *Naturopathy for Blue Diamond and Litunga benefit options.*
- ***Dentistry:***
  - *Labial and Lingual frenectomies in respect of beneficiaries under the age of 8 years.*
  - *General anaesthetics, conscious analgo sedation and hospitalisation for dental work, except in the case of patients under the age of 10 years or bony impaction of the third molar.*
- ***Medical expenses:***
  - *Robotic assisted surgery, unless authorised.*
- ***Blood tests:***
  - *Blood tests requested by a Homeopath, Naturopath and Phytotherapists.*

Healthcare
fraud, waste and abuse

Healthcare fraud, waste and abuse costs the healthcare industry millions, if not billions, every year. This cost eventually leads to higher healthcare costs and medical aid contributions for which you, the member, pay for. Awareness of these issues is an important aspect in order to spot and identify healthcare fraud, waste and abuse.

If you still have questions or concerns after talking to your healthcare provider, inform your medical aid or call the toll-free fraud hotline at 0800 647 000.

NHP Contact information

Get in touch

Head office: Windhoek

Tel	061 285 5400
Fax	061 223 904
Website	www.nhp.com.na
Walk-in assistance	Unit 2, Demushuwa Suites Corner of Grove and Ombika Street Kleine Kuppe
Postal address	PO Box 23064, Windhoek
Operating hours	Monday to Friday 07:45 - 17:00 Saturday 08:00 - 13:00

Fraud hotline - Confidential

Tel	0800 647 000
Email	fraud@medscheme.com.na

NHP emergency numbers

(Monday to Sunday until 22:00)

After hours	081 372 9910
In-hospital	081 246 8436

Dedicated emergency medical assistance

E-Med Rescue 24	061 222 223
LifeLink EMS	064 501 000

Branches

Windhoek: Sanlam Walk-in Centre

Tel	085 268 3400
Email	moutonr@medscheme.com.na
Walk-in assistance	Ground floor, Sanlam Centre 145 Independence Avenue

Swakopmund

Tel	064 405 714
Fax	064 403 715
Email	swakop@nhp.com.na
Walk-in assistance	Office number 2 1st floor, Food Lovers Market 50 Moses Garoeb Street
Postal	PO Box 2081, Swakopmund

Walvis Bay

Tel	064 205 534
Fax	064 209 959
Email	walvis@nhp.com.na
Walk-in assistance	Office No. 7, Welwitschia Hospital Centre
Postal	PO Box 653, Walvis Bay

Oshakati

Tel	065 221 721
Fax to email	061 277 412
Email	oshakati@nhp.com.na
Walk-in assistance	Medical Complex, Main Street
Postal	PO Box 23064, Windhoek

Keetmanshoop

Tel	063 225 141
Fax to email	061 277 419
Email	keetmans@nhp.com.na
Walk-in assistance	Bird's Mansion Hotel, 6th Avenue
Postal	PO Box 1541, Keetmanshoop

Dedicated

Aid for AIDS (AfA) Programme

Tel	061 285 5423
Fax	061 271 674
Email	info@afa.com.na

Oncology Programme

Tel	061 285 5422
Fax	061 277 408
Email	oncology@nhp.com.na

Wellness / BRM / Lifestyle Programme

Tel	061 285 5437
Fax	061 231 282
Email	wellness@nhp.com.na

Clinical risk

Chronic Medicine Management

Tel	061 285 5417
Fax	061 277 408
Email	chronicapp@nhp.com.na

Support

Membership

(Applications, contributions and amendments)

Tel	061 285 5400
Fax	061 230 465
Email	members@nhp.com.na

Ex-Gratia

exgratia@nhp.com.na

Optical

optics@nhp.com.na

Claims

Tel	061 285 5400
Fax	061 223 904
Email	claims@nhp.com.na

Hospital pre-authorisation

Tel	061 285 5400
Fax	061 277 408
Email	cases@nhp.com.na

International Travel Insurance

Tel	061 285 5400
Fax	061 223 904
Email	nhptravel@nhp.com.na

New business

Tel	061 285 5407
Fax	061 231 282
Email	newbusiness@nhp.com.na

Healthcare providers

Tel	061 285 5444
Fax	061 277 404
Email	providers@nhp.com.na