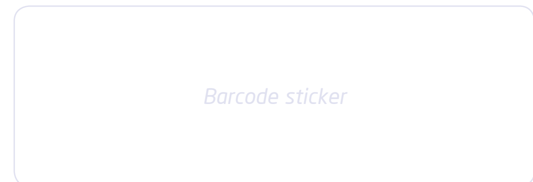
Membership application form
Confidential

tel 061 285 5400
fax 061 230 465
email members@nhp.com.na
website www.nhp.com.na
Unit 2, Demushuwa Suites, Corner of Grove and Ombika Street,
Kleine Kuppe, Windhoek
PO Box 23064, Windhoek, Namibia
Reg No: MOHSS 003



For office use only

Membership

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

Benefit option ☐ Gold ☐ Platinum ☐ Titanium ☐ Bronze ☐ Silver
☐ Hospital ☐ Blue Diamond ☐ Litunga

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

Group number (if applicable) ______

Clinical and underwriting

☐ Accepted ☐ Rejected

General waiting period ☐ 3 month ☐ 12 month ☐ No waiting period

Condition specific waiting period ☐ 12 month maternity

Underwriting decision ______

______

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 are 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.

- [ ] ID/Passport of principal member
- [ ] Marriage certificate (if applicable)
- [ ] ID/Passport of spouse
- [ ] Full birth certificate(s) of children
- [ ] Previous medical aid(s) membership certificate
- [ ] Doctor's certificate
- [ ] Copy of the bank statement/cancelled cheque/letter from the bank/bank letterhead confirming your account 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 D D M M Y Y Y Y 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 it 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 dependant(s) been a member of NHP in the past? ☐ Yes ☐ No

Membership number ______ Status ☐ Principal member ☐ Dependant

Have you or any of your dependant(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

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	Private member	Member of employer group	
	Continuous member	Membership number	
Benefit option choice	Gold	Platinum	Titanium
	Bronze	Silver	Hospital
	Blue Diamond*	Litunga*	
Roll-Over benefit (once accumulated)	Automated	Manual	
Monthly contribution	N$	I wish to join NHP from	0 1 M M 2 0 Y Y

* For a full list of our Designated Service Providers, please contact one of our branches or visit 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			
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

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 (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

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

☐ Doctor's initial(s)

Section 6 Principal member and dependant(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 ☐ Yes ☐ No
e.g. Deafness, ear infections, sinus, tonsillitis, allergic rhinitis, allergies etc.

8. Any problem/disorder with eyes ☐ Yes ☐ No
e.g. Defective vision, eye surgery, lens implant, cataracts, glaucoma, rentinitis pigmentosa, retinal detachment etc.

9. Any problem/disorder with teeth ☐ Yes ☐ No
e.g. Speech impairment, harelip, cleft palate, orthodontic treatment, gum/tooth disorder, abnormal bite etc.

10. Any disorders of the endocrine system ☐ Yes ☐ No
e.g. Thyroid disorder, Cushing's syndrome, Addison's disease, gland problems, pancreatic disorder/metabolic syndrome etc.

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? ☐ Yes ☐ No
(please specify)

11. Women's health ☐ Yes ☐ No
e.g. Endometriosis, infertility, ovarian cysts, hysterectomy, abnormal pap smear, biopsies, hormone replacement therapy etc.

12. Any disorder of the immune system ☐ Yes ☐ No
e.g. Any immunological disorder, Lupus etc.

13. Any psychological disorder ☐ Yes ☐ No
e.g. Depression (please specify type), anxiety/panic attacks, psychosis, bipolar disorders, schizophrenia, psychotherapy, alcohol or drug abuse, attention deficit disorder, bulimia etc.

14. Any disorder of the musculoskeletal system ☐ Yes ☐ No
e.g. Fractures, spinal/hip/knee condition, plegia, osteoporosis, muscular dystrophy, rheumatoid/osteo arthritis, fibromyalgia etc.

15. Any disorder of the respiratory system/lung conditions ☐ Yes ☐ No
e.g. Asthma, bronchiectasis/chronic cough, emphysema (COPD), pneumonia, cystic fibrosis, chronic bronchitis etc.

15.1. Do you or your dependants smoke? ☐ Yes ☐ No
(please specify)

16. Any disorder of the skin ☐ Yes ☐ No
e.g. Eczema, acne, dermatitis, growths, keloids, psoriasis, allergies, scleroderma, lupus etc.

17. Any urology disorder ☐ Yes ☐ No
e.g. Prostate disorder, prolapse bladder, urinary infections, kidney stones, blood in urine etc.

18. Any infectious/tropical disease ☐ Yes ☐ No
e.g. Bilharzia, malaria, tuberculosis (TB), hepatitis, sexually transmitted disease etc.

19. Are you or your dependants currently on any medication? ☐ Yes ☐ No
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.

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? ☐ Yes ☐ No
(within the next 12 months)

☐ Doctor's initial(s)

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

22. Women only

22.1. Are you or any of your dependants pregnant or suspect that you are pregnant? ☐ Yes ☐ No
(pregnancy test will be required)

22.2. If yes, how many weeks? ☐ Weeks

22.3. If yes, are you carrying more than one child? ☐ Yes ☐ No
e.g. Twins, triplets etc.

		Principal member		Dependant	
23.	Has your mass changed (gain or loss) by more than 5kg during the past year? (please specify)	☐ Yes	☐ No	☐ Yes	☐ No
23.1.	Height (without shoes)		cm		cm
23.2.	Weight (without shoes)		kg		kg
23.3.	Waist measurement (circumference)		cm		cm
23.4.	Hip measurement (circumference)		cm		cm

If you/your doctor have answered 'yes' to any of the above questions please complete the details below in full. If more space is needed, please attach list. If you are HIV positive, please contact our AfA Programme upon approval of your application.

No	Detail

Doctor acknowledgment and declaration

Title ______ 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

D D M M 2 0 Y Y

Date

Practice stamp

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 chronicapp@nhp.com.na. Please contact the call centre, tel 061 285 5400 or download the form from 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
			DDMMYYYY	DDMMYYYY
			DDMMYYYY	DDMMYYYY
			DDMMYYYY	DDMMYYYY
			DDMMYYYY	DDMMYYYY
			DDMMYYYY	DDMMYYYY
			DDMMYYYY	DDMMYYYY
			DDMMYYYY	DDMMYYYY

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/cancelled cheque/letter from the bank/bank letterhead confirming the account holder's details.
4. Account holder's signature.

Banking details

Use this bank account for ☐ CONTRIBUTIONS and/or ☐ REFUNDS

Name of account holder Title ____ Initials ____ First name(s) ____

Surname ____

Bank ____ Branch ____

Branch code ____ Type of account ____

Account number ____

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 and 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

D D M M 2 0 Y Y
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 my or my dependant(s) circumstances change 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. *If my application is successful I agree to NHP, its Administrator and its Managed Care organisation collecting, using, processing, retaining and sharing my and my dependants' health and benefit information for the following purposes:*
    - *for the administration of my benefit option;*
    - *for providing managed health care services to me or my dependant/s based on my benefit option;*
    - *for providing relevant information to a contracted third party who requires this information to provide a healthcare service to me or my dependant/s on my benefit option;*
    - *for any managed heathcare programme or initiative that will benefit me or my dependant/s in managing any managed healthcare condition and to optimise my medical scheme benefits.*

    I understand that this information will be kept confidential and will not be disclosed to any other party except for the purposes stated above.

11. *I hereby authorise the Fund to share my and my dependants' personal and healthcare information with the Fund healthcare management facility, the Fund's administrator or the relevant government authorities for administrative and statistical purposes, provided such information shall be treated as confidential at all times.*

12. *I declare that I and my dependant(s) are not beneficiaries of another registered medical aid fund.*

13. *I authorise and permit NHP to take all reasonable steps to verify information provided by me in this application form.*

14. *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.*

15. *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.*

16. *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).*

17. *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.*

18. *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.*

19. 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.

_______________________________ _______________________________

Signature of principal member *Signature of witness*

Signed at ______________________________ on this ______________ day of ___________ 20 ____

Please note:

Waiting periods may apply to your membership.

A general waiting period lasts 3 months. During this period, you and your dependants are not entitled to claim any benefits, except, in some circumstances, including emergencies.

A condition-specific waiting period lasts 12 months. During this period, you and your dependants are not entitled to claim benefits related to a specific condition.