



We're about you

Ex-Gratia request Confidential

tel 061 285 5400

fax 061 277 408

email exgratia@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

Please note In order for the administrator to deliver efficient service to you, it is important that you provide and complete all information as required. Print clearly using **capital** letters. Only **one** character per block. Leave open **one** block between words. Mark with an **X** where necessary.

Prerequisites for completion and processing

1. The application form must be completed in full, i.e. all information required must be provided. Please do not leave any spaces blank, or delete, without reading and providing the detail as required.
2. The Medical Advisory Board may make Ex-Gratia awards only if the Board of Trustees, in its absolute discretion is satisfied that the member would otherwise suffer undue financial hardship.
3. All claims in excess of the benefit limits must be submitted prior to the Ex-Gratia Committee, making its decision.
4. In the space provided below, please indicate to whom the Ex-Gratia award(s) must be paid over to; should this application be successful.

Check list (compulsory)

Please note We cannot process your application if it is incomplete, incorrect, or if you have not attached the correct documents. Please use this check list to make sure that you are sending us a copy of everything we need.

- Medical report - Including treatment costings
- Proof of income for both principal and spouse/partner - A copy of latest salary slip and 3 months bank statement
- If you are a business owner - A copy of your latest audited financials and 3 months bank statement

Particulars for payment

Pay member Pay supplier Please specify

Particulars of principal member (must be completed)

Membership number Date of commencement

D	D	M	M	2	0	Y	Y
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Title Initials First name(s)

Surname Age

Tel(H) Tel (W)

Cell Fax

Email

Postal address Postal code



Particulars of Dependant(s) (if applicable)

Please note 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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> M <input type="text"/> F	<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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> M <input type="text"/> F	<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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> M <input type="text"/> F	<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
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<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> M <input type="text"/> F	<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

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"/>	Eligible start date	<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.

<hr/>	Company stamp
Name of company official	
<hr/>	
Signature of company official	

What is the nature of request?

Name of patient	Title <input type="text"/>	Initials <input type="text"/>	First name(s) <input type="text"/>
	Surname <input type="text"/>		
Membership commencement date	<input type="text"/>	Benefit option	<input type="text"/>
Date of birth	<input type="text"/>	Gender	<input type="text"/> M <input type="text"/> F
Tel (H)	<input type="text"/>	Occupation	<input type="text"/>
Cell	<input type="text"/>	Tel (W)	<input type="text"/>
Email	<input type="text"/>	Fax	<input type="text"/>

- Have you previously applied for Ex-Gratia? Yes No
- Are you claiming from an insurer or a third party other than NHP? Yes No
- Are your benefits exceeded Yes No
- Is treatment not covered by NHP? Yes No
- Is your claim submitted more than 4 months after the date of service? Yes No

If yes to any of these questions, please provide details



Members' motivation for Ex-Gratia

Please note Please attach all documents relevant to the motivation of this application.

Five empty rectangular text boxes for providing motivation details.

Doctors' report (to be completed by doctor)

Diagnosis

Please note Please attach detailed motivation letter and where applicable photographs.

Four empty rectangular text boxes for providing diagnosis details.

Medical history

Six empty rectangular text boxes for providing medical history details.

Treatment and medication required

Please note Please attach detailed quotation.

Six empty rectangular text boxes for providing treatment and medication details.

Doctor acknowledgment and declaration

Form fields for doctor information: Title, Initials, First name(s), Surname, Practice number, Tel (W) with separate boxes for area and number, Fax with separate boxes for area and number, Email, and How many months/years has he/she been your patient? with a text box.

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



Statement of income and expenditure (to be completed by member)

	Member	Spouse/Partner	Total
Monthly income (CTC)	N\$ _____	N\$ _____	N\$ _____
Net salary	N\$ _____	N\$ _____	N\$ _____
Net pension	N\$ _____	N\$ _____	N\$ _____
Other income	N\$ _____	N\$ _____	N\$ _____
Total deductions	N\$ _____	N\$ _____	N\$ _____
Total net income	N\$ _____	N\$ _____	N\$ _____

Monthly expenditure

Fixed

PAYE	N\$ _____
Pension contribution	N\$ _____
Rent/Bond	N\$ _____
Medical aid fund	N\$ _____
Social security	N\$ _____
Maintenance of ex-spouse	N\$ _____
Bank loans	N\$ _____
Staff	N\$ _____
Study	N\$ _____
Hire purchases	N\$ _____
Insurance: Life	N\$ _____
Insurance: Endowment	N\$ _____
Insurance: Retirement annuity	N\$ _____
Other medical	N\$ _____
Household	N\$ _____
Homeowner	N\$ _____
Car	N\$ _____
Credit card payments	N\$ _____
Total fixed expenses	N\$ _____

Monthly provision for annual payments

TV license	N\$ _____
Car license	N\$ _____
Income tax	N\$ _____
Other	N\$ _____
Total monthly provision	N\$ _____

Variable

Groceries and toiletries	N\$ _____
Wages: Domestic	N\$ _____
Wages: Gardener	N\$ _____
Water and electricity	N\$ _____
Rates and taxes	N\$ _____
Telephone: Home	N\$ _____
Cell phone	N\$ _____
Transport	N\$ _____
Clothing	N\$ _____
Entertainment	N\$ _____
School: Fees	N\$ _____
School: Transport	N\$ _____
School: Sport	N\$ _____
School: Tuck	N\$ _____
Other	N\$ _____
Total variable expenses	N\$ _____

Possible monthly payments

Gifts	N\$ _____
Newspaper	N\$ _____
Other	N\$ _____
Total monthly possibilities	N\$ _____

Summary of income and expenditure

Monthly income

Net salary: Self	N\$ _____
Net salary: Spouse	N\$ _____
Other income	N\$ _____
Total income	N\$ _____
Net monthly	N\$ _____

Monthly expenditure

Total: Fixed expenditure	N\$ _____
Total: Variable expenditure	N\$ _____
Total: Monthly provisions	N\$ _____
Total: Monthly possibilities	N\$ _____
Total: Expenditure	N\$ _____

Statement of assets and liabilities (to be completed by member)

Assets	Value	Liabilities	Value
Residential property owned	N\$ _____	Mortgage bonds	N\$ _____
Other properties owned	N\$ _____	Bank overdraft	N\$ _____
Shares and investments	N\$ _____	Loans	N\$ _____
Debtors and loans: Cash in the bank	N\$ _____	Loans	N\$ _____
Debtors and loans: Cash in the bank	N\$ _____	Creditors	N\$ _____
Other significant assets	N\$ _____	Other significant liabilities	N\$ _____
Total	N\$ _____	Total	N\$ _____

Acknowledgment and declaration

I, the undersigned, hereby certify that the information furnished by me in this application is complete, true and correct. I authorise my doctor to disclose information to NHP, provided such information is treated as confidential at all times.

D	D	M	M	2	0	Y	Y
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Signature of principal member

Date

