

# Membership Application Form

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**Renaissance Health**  
Medical Aid Fund

Existing Membership Number (Continuation members)											

Shaded areas for office use only

Membership Number (New)											

Processed By											

Date											

<b>Exclusion (s)</b>	Approved by:
1 _____	_____
2 _____	_____
3 _____	Date: _____
4 _____	_____

## Section A - Employment Details

Company Name \_\_\_\_\_

Nature of Industry \_\_\_\_\_

Company Address \_\_\_\_\_

Telephone Number ( \_\_\_\_\_ ) \_\_\_\_\_

Postal Address \_\_\_\_\_

Employee Number  Date of Employment

Designation of Employee

CB Number					

## Section B - Member Details

Title \_\_\_\_\_ Initials \_\_\_\_\_ Full Names \_\_\_\_\_

Surname \_\_\_\_\_

Physical Address \_\_\_\_\_

Postal Address \_\_\_\_\_ Postal Code \_\_\_\_\_

Telephone Numbers (H) Code ( \_\_\_\_\_ ) \_\_\_\_\_ (W) Code ( \_\_\_\_\_ ) \_\_\_\_\_

Cellphone \_\_\_\_\_ Fax \_\_\_\_\_ E-mail: \_\_\_\_\_

Date of Birth  Age \_\_\_\_\_ I.D. / Passport Number \_\_\_\_\_

Marital Status  Single  Married  Divorced  Widowed  Common Law

Proposed Date of Joining

## Section C - Previous Medical Membership

Supply details of previous Medical Aid membership and attach proof of previous membership.

Membership Period			Name of previous Medical Aid
Date Joined	Date resigned	Membership number	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

# Membership Application Form

## Section D - Beneficiaries to be Covered

ID/Passport Number	First Name	Surname	Relationship	Gender	Date of Birth

Relationship abbreviations: SP - Spouse, CD - Child Dependant, AD - Adult Dependant

## Section E - Product Option Selection

### Main product

- Elite Care Plan       Prestige Care Plan       Status Care Plan       Express Care Plan   
 Econo Care Plan       Primary Care Plan       Vital Care (for groups of 10 members and more)

### Benefit Builder Selection

Beneficiary Name	Date of Birth	Optical Plan		Dental Plan		Consultations Plan		Acute Medication Plan		Medical Services Plan		Chronic Plan			Auxiliary & Essential Services	
		Standard	Executive	Standard	Executive	Standard	Executive	Standard	Executive	Standard	Executive	Basic	Standard	Executive	Standard	Executive

### Inclusive Insurance Products

Please take note that the option selected include the following insurance benefits of which the **risk** is fully underwritten by a registered insurer, Prosperity Life as required by the Medical Aid and Insurance Acts: Emergency Evacuation Cover, Memorial Transportation Cover, Premium Protection Cover and Travel assistance.

### Optional Insurance Products

The Following Insurance Benefits are not included in the options selected and is optional. The **risk** of these products is fully underwritten by a registered insurer, Prosperity Life as required by the Medical Aid and Insurance Acts:

- Funeral Cover       Complimed Gap Cover

Please mark with an X if the cover is required.

## Section F - Bank Details (For contribution payments and Electronic Claim Refunds.)

**IMPORTANT NOTICE:** It is compulsory to supply Prosperity Health with this information. (In the event that refunds should be deposited into a different banking account, attach details as well)

- Claims Refunds       Contribution Payments

Name of Account Holder \_\_\_\_\_

Bank Name \_\_\_\_\_ Branch Name \_\_\_\_\_

Branch Code  Account Number

Type of Account: Cheque       Transmission       Savings

Signature of Account Holder

## Section G - Documentation

The following documentation should accompany the application form as per the Financial Intelligence Act 2007 (FIA) where applicable:

- ID/Passport of main member
- Proof of banking details (e.g. cancelled cheque, bank statement, etc.)
- Payslip for options Primary Care and Econo Care
- Marriage certificate when registering a spouse
- ID/Passport of spouse
- Birth certificates of children (full birth certificate should surname differ from main member)
- Proof of full-time study at a registered technicon or university for child dependants 21 to 25 years of age
- Medical certificate for mentally/physically disabled children over 21 years of age

# Membership Application Form

## Section H - Medical History

Supply full details on questions below. Where an answer to a question is "yes" - provide details in the space provided below  
Questions pertain to Applicant and ALL beneficiaries

Have you/your spouse or any one of your beneficiaries ever experienced any of the following?

Please mark (✓) the relevant box

			Answer	
			Yes	No
1	Cardio Vascular	Chest pain/angina, heart attack, heart failure, heart valve disease, rheumatic fever, high blood pressure, (hypertension), high cholesterol, heart murmurs, circulatory problems/disorders, varicose veins, deep vein thrombosis (DVT), or any other heart or circulatory problems.		
2	Respiratory & Breathing	Asthma, difficulty with breathing, bronchospasm, tuberculosis (TB), coughing up blood, emphysema, pneumonia, cystic fibrosis, chronic bronchitis, shortness of breath, any other breathing problems. Smoking		
3	Bladder & Kidneys	Blood in urine, kidney failure, polycystic kidneys, kidney or bladder infections, removal of kidney (nephrectomy), kidney stones, abnormal kidney or urine tests or any other kidney problems.		
4	Reproductive & Gynae	Endometriosis, infertility, ovarian cysts, hysterectomy, abnormal PAP smear, laser treatment, cervix and breast biopsies, fibro-adenosis of the breast, laparoscopies, hormone replacement therapy, prostate infections or surgery, prostate enlargement or any other reproductive problems.		
5	Digestive System	Duodenal ulcers, gastric ulcers, peptic ulcers, hiatus hernia, colon problems, crohn's disease, ulcerative colitis, gall bladder problems, liver problems or any other digestive problems. Obesity		
6	Ear, Nose and Throat	Deafness, ear infections, sinus problems, nasal surgery, throat surgery, tonsils.		
7	Dental	Orthodontic treatment, dental surgery, speech impairment, harelip, cleft palate, or any other such surgery.		
8	Eyes	Blindness (partial or full), eye surgery, lens implant, cataracts, glaucoma, renitis pigmentosa, retinal detachment, impaired vision, or any other eyesight problems.		
9	Endocrine	Diabetes melitus or insipidus, underactive thyroid, overactive thyroid, thyroid surgery, crushing's syndrome, addison's disease, pituitary gland, gland problems or any other glandular problems.		
10	Back and Muscles	Neck or back problems or operations, recurrent back pain, osteoporosis, ankylosing spondylitis, rheumatoid arthritis, osteo-arthritis, disease, or any other bone or skeletal disorders.		
11	Neurological	Epilepsy, stroke (CVA), migraine, brain or head injuries, spinal cord injuries, paralysis, multiple sclerosis, mental retardation, narcolepsy, motor neuron disease, parkinson's disease, alzheimer's disease, or any other neurological problems.		
12	Psychological	Depression, anxiety, psychosis, suicide attempts, bipolar disorders, manic depression, "Stress", schizophrenia, tourete's syndrome, anorexia nervosa, received advice, counselling or hospitalisation for alcohol or drug abuse, attention deficit disorders, Bulimia or any other psychological conditions.		
13	Tumours and Growths	Benign or malignant growths or lumps or tumours including melanoma, lymph gland cancer, leukaemia, breast cancer or any other tumours, growths and cancers.		
14	Blood	Blood or bleeding disorders e.g. haemophilia, christmas factor deficiency, platelet or any other blood clotting disorders.		
15	Skin	Eczema, acne, dermatovositis, psoriasis, scleroderma, or any other skin disorders		
16	Sexually Transmitted Disease	Advice, treatment or counselling for any of the following: HIV/AIDS, syphilis, gonorrhoea, herpes, genital ulcers, pelvic infectious disease, genital warts, hepatitis B or any other sexually transmitted disease or disorders.		
17	Hospitalisation	Have you, your spouse or any dependants ever been hospitalised? If yes how frequently?		
18	Treatment & Surgery	Are you, your spouse or any dependants expecting any medical or dental advice, treatment, or are you planning any such treatment within the next three to six months?		
19	Dangerous Pastimes	Are you, your spouse, or any dependants participating in any hazardous sport or occupations, e.g. motor or motorbike or motorboat racing, dragster racing, bungee jumping, skydiving, scuba diving or any other hazardous pursuits?		
20	Pregnancy	Are you, your spouse, or any dependants currently pregnant? Should the answer be "yes", when is the expected date of delivery (yyyy/mm/dd)		
21	Other	Are there any other factors related to you or your beneficiaries' health that is not disclosed above?		
22	Planned Treatment	During the last 12 months, have you, your spouse or any dependants had any treatment or are you planning any treatment within the next six months?		

If the answer to any of the above questions is "yes", please give a short summary.

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# Membership Application Form

## Section I - Declaration by Applicant/Principal Member

In this declaration the singular shall imply the plural

1. I the undersigned, hereby apply for myself and my beneficiaries to join as a member of Renaissance Health Namibia.
2. I declare that this application, and declaration together with statements made by me, whether in writing or not, are true and correct and agree that such statements together with any forms, reports or other information completed or supplied by me or any other party on my behalf shall form the basis of this contract.
3. I agree to be bound and to abide by the rules, standard terms, conditions and any rules ordinarily used by Prosperity Health for types of benefits for which I have applied, and Prosperity Health shall not be bound in any way by any representations or undertakings made or given by any person or agent save in the Registered Rules of the Fund.
4. It is further agreed and understood that, notwithstanding any statements made to the contrary by any person, membership will not commence and no liability whatsoever will attach to Renaissance Health unless express written notice of acceptance of risk is given by Prosperity Health.
5. It is also agreed and understood that membership will only commence on the 1st day of the month following receipt of payment by Prosperity Health.
6. I irrevocably authorise any medical practitioner, hospital, medical institution or other person to disclose information which may be related to my occupation, physical or mental health, including the results of any tests, to Prosperity Health and I agree that this authorisation shall remain in force after my death.
7. I indemnify Prosperity Health and its creditors, agents and employees against any claim of whatever nature, which may be made against them as a result of or arising out of disclosure, medical information or any costs incurred as a result of being a member of this Medical Aid Fund.
8. I further accept that the provisions of any declaration made have been read and understood by me and will also apply *mutatis mutandis* to and form part of this application.
9. I authorise Prosperity Health to debit my bank account, details of which have been provided to Prosperity Health, for any amount due in terms of the membership applied for.
10. I undertake to advise Prosperity Health of any change in the status of health of myself, or any of my beneficiaries, which occurs prior to my receiving acceptance of this application.
11. I declare that no material fact has been withheld, misstated or concealed by me and that I will disclose all material facts prior to acceptance of the risk and I agree that any misstatements and/or omission of any material information will render my membership null and void, and in such event all monies paid in respect thereof shall be forfeited.
12. I hereby acknowledge that any credit extended by Renaissance Health to myself or my dependants whilst being members of Renaissance Health, will become payable in full upon termination of my membership of Renaissance Health and that interest may be charged on all amounts owing to Prosperity Health.
13. I further acknowledge that on termination of membership, any amounts owing to the Fund will be deducted from any amounts due to me from my Employer. For this purpose I hereby permit Prosperity Health to advise my Employer of any amounts due to Prosperity Health.
14. I acknowledge that the products offered by the Renaissance Health Medical Aid Fund may incorporate Insurance products of which the risk is fully underwritten by a registered insurer, Prosperity Life in terms of the Medical Aid & Insurance Acts. The Terms and conditions of these products can be obtained from the insurer on request.
15. I acknowledge that in the event of any modification or variation of this standard form, Prosperity Health will regard this form as being invalid and of no force and effect.

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

Print Name \_\_\_\_\_

Applicant/Principal Member name \_\_\_\_\_

Applicant/Principal Member signature \_\_\_\_\_

## Section J - Employer Warranty

**Compulsory for members belonging to Group Schemes**

Name of Company

Effective Date

### Management Representation

Name

Designation

Signature

Company Stamp