

MEMBERSHIP BENEFICIARY REGISTRATION FORM

Section C - Registration of beneficiaries *(Please tick appropriate box.)*

Married (refer to Note 3 below)				Divorced				Widowed															
My Spouse is not a member of another scheme																							
My Spouse is a member of a registered scheme						If this block is ticked, please complete section D below.																	
My Spouse is employed at (Name of company)																							
Date of marriage/divorce/death		D	D	M	M	Y	Y	Y	Y														
DEP CODE	FULL NAMES	SURNAME			DATE OF BIRTH				BENEFIT DATE				A	B									
						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		
						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		
						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		

Note: 1) In case of adoption, copies of the adoption papers must accompany this form.
 2) State reason for registration or termination of the above dependant(s).
 3) In case of marriage, copies of the marriage certificate must accompany this form.
 4) In case of birth, full birth certificate must be attached.

Codes: A - Relationship (S - Spouse) (C - Child)
 B - Gender (M - Male) (F - Female)

Section D - Previous/Current Medical Membership

Supply details of previous/current Medical Aid membership and attach proof of membership of your beneficiaries.

Name of previous/current Medical Aid Fund																					
Membership Number		Date Joined				Date Resigned															
						D	D	M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y

Section E - Documentation *The following documentation should accompany the application form as per the Financial Intelligence Act 2012 (FIA) where applicable:*

Namibian Citizen		Yes		No									
ID / Passport of main member				Birth certificates of children (full birth certificate)									
Proof of banking details (Please attach confirmation from the bank)				Proof of full-time study at a registered technikon or university for child dependants 21 to 25 years of age									
Payslip for options Evolve Care, Premiere Care and Esteem Care				Medical certificate for mentally/physically disabled children over 21									
Marriage certificate when registering a spouse / ID / Passport of spouse													
Identification and Verification: Financial Intelligence Act, 13 of 2012 (FIA)													
I hereby confirm that the information provided to me by the Policyholder, has been verified against the documentation provided and that the identity of the Policyholder has been established and verified as required in terms of Section 21 of the FIA.													
Broker / Agent Name				Date		D	D	M	M	Y	Y	Y	Y
Signature of Broker / Agent													

Section H - Declaration by Principal Applicant

In this declaration the singular shall imply the plural.

1	I, the undersigned, hereby apply for membership to Renaissance Health Medical Aid Fund ("RHMAF") on behalf of myself and beneficiaries.									
2	I declare that this application and declaration together with any statements or representations made by myself, whether in writing or otherwise, are true and correct and I agree that such statement(s) or representation(s), together with any forms, reports or other information competed or supplied by myself, or any other requisite party on my behalf, inclusive of PSEMAS, any other medical aid or medical insurer of which I was a member and any service provider shall form the basis of this agreement and any underwriting effected in regard to my application, in respect of myself of my beneficiary(ies).									
3	agree on behalf of myself and my beneficiaries, to be bound by and to abide to the Fund Rules, Benefit Rules, standard terms and conditions and any Rules ordinarily utilised by RHMAF in respect of benefits for which I have applied. Neither RHMAF nor Prosperity Health, unless expressly stated in writing, shall not be bound in any manner by any misrepresentations or undertakings made or given by any person or agent.									
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 agreed and understood that membership will only commence on the 1st day or the month following receipt of payment by Prosperity Health in favour of RHMAF in respect of a membership contribution.									
6	I irrevocably authorise and provide informed consent on behalf of myself and beneficiary(ies) as the context permits, any medical practitioner, hospital medical institution, pathology laboratory or other relevant person to disclose information which may be related to my occupation, physical or mental health, inclusive of the results of any tests to Prosperity Health/RHMAF and I agree that this authorisation shall remain in force after my death. In so far as it relates to a disease management programme under the auspices of RHMAF, I additionally authorise RHMAF/Prosperity Health to submit my data to requisite associates such as my GP or pharmacist in so far as either myself or my beneficiaries elect to participate in a disease management program.									
7	I indemnify Prosperity Health and it's 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 the 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 <i>mutatis mutandis</i> to and form part of this application.									
9	To advise Prosperity Health on behalf of RHMAF as the Administrator 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 on behalf of RHMAF as the Administrator 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(s) have been withheld, misstated or concealed by myself or in respect of my beneficiaries and that I herewith unequivocally undertake to disclose all material facts prior to acceptance of the risk and I agree that any misrepresentation, misstatements and or omission(s) of any material information, particularly in so far as it relates to disclosure of medical information pertinent to risk, will render my membership null and void.									
12	I hereby acknowledge that Renaissance Health Medical Aid Fund does not extend credit for myself or my dependants whilst being a members of Renaissance Health Medical Aid Fund, therefore upon termination of membership of Renaissance Health Medical Aid Fund, all outstanding payable credit and interests 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 by my Employer. For this purpose I hereby permit Prosperity Health to advise my Employer of any amounts due to RHMAF.									
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 relevant Medical Aid and Insurance legislation. The terms and conditions of these products may be obtained from Prosperity Health 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.									
16	I understand that any changes to this document as well as membership status of any of myself or any of my beneficiaries will require the completion of the necessary forms.									
17	I hereby acknowledge that I have included my current salary advice / 3 month bank statement as well as declared my current insurance and the reason for it.									
18	I hereby acknowledge that I understand that the product selected has an overall annual limit with applicable sub limits.									
19	I understand and agree to all the above:									
Signed at	<table border="1"> <tr> <td></td> <td>on this</td> <td></td> <td>day of</td> <td></td> <td>2</td> <td>0</td> <td></td> <td></td> </tr> </table>		on this		day of		2	0		
	on this		day of		2	0				
Print Applicant Name										
Applicant Signature										

Section I - Disclaimer

1	Upon membership being granted, every Member shall, by virtue of his/ her signature on the application form, be deemed to have acknowledged that he/ she and his/ her dependants are bound by the Rules and any annexures and amendments thereto. A copy of the Fund Rules can be obtained from the Fund on request by any Member.
2	Upon membership being granted, every Member shall, by virtue of his/ her signature on the application form, consent to the use of their medical data for medical purposes/programs such as managed care programs to be used / disclosed by the Fund to services providers of the Fund subject to confidentiality and protection of the member's information.

Section J - Addendum

RHMAF hereby extends its sincerest gratitude to you for considering us as your potential medical aid of choice. Kindly note the below details prior to completing the application form. Please do not resign from your current medical aid fund or medical insurer prior to obtaining approval of your application in writing. Should any further information be required in this regard please feel free to contact the Client Services Department at Tel: +264 83 2999 736.

1. It is very important that the application form be completed in full in order to ensure that all due considered information is provided.
2. We urge you to note the importance of the medical history section in respect of which we encourage prospective members to be most forthcoming as any omission or misrepresentation of fact may have serious consequences in respect of membership.
3. Where the RHMAF elects to effect restrictions or exclusions on the principal member or any of the members' beneficiaries, this will be communicated in writing to yourself for approval of the restrictions/exclusions, once signed off by yourself, the registration process may then be completed.
4. Where a member applies for membership during the course of a benefit year, it is important to take note that membership will be pro-rated.
5. It may be required that you be requested to provide additional information or undergo medical testing in order to ensure the processing of your application, if this is required you will be duly informed.