OPTION CHANGE / BENEFIT BUILDER / BANK DETAIL UPDATE FORM

Tel: +a264 83 2999 736
E-mail copy of completed form to : rhmafmember@prosperitynam.com

Renaissance Health
Medical Aid Fund

Section A - Principal Member Details

Private		Company								
Member Number										
First Name & Surname										
Telephone Number										
Cellphone Number										
E-mail Address										
Physical Address										
Postal Address										
Spouse Name & Surname										
Spouse Cellphone Number										

Section B - Product Option Selection *(Effective annually 01st January)*

Effective Date: 0 1 M M Y Y Y Y

Elite Care		Prestige Care		Status Care	
Caliber Care		Esteem Care *(Individual Contribution - Age based)*		*Esteem Care *(Group Contribution - Age/Income based)*	
Evolve Care *(Individual Contribution - Age based)*		Evolve Care *(Group Contribution - Age/Income based)*		*Premiere Care (For groups of 10+ members)	

** Only applicable to Group Schemes. Salary advice should be attached. A maximum salary scale applies.*

Section C - Benefit Builder Selection *(Period of cover up to 31 December)*

General rules

- We pro-rate Benefit Builders according to when you buy the options.
- Benefit Builders are not available if you belong to the Primary or Vital Care options.
- Benefit Builders may only be purchased once per family per annum.

80% of unused benefits in a family Benefit Builder selected by the member in previous benefit year will be transferred in the following year to the member's Benefit Wallet as a top up medical benefit for use when needed. (Note: The balance is transferred after 4 months to allow for the run-off of medical claims incurred in the previous year.)

Benefit Builders *(A Benefit Builder automatically terminates on the 31st December of the applicable benefit year.)*

Family Benefit		Monthly Contribution	Effective Date	Family Benefit		Monthly Contribution	Effective Date
N$ 3,000		N$ 225	D D M M Y Y	N$ 15,000		N$ 1,125	D D M M Y Y
N$ 5,000		N$ 375	D D M M Y Y	N$ 17,000		N$ 1,275	D D M M Y Y
N$ 7,000		N$ 525	D D M M Y Y	N$ 20,000		N$ 1,500	D D M M Y Y
N$ 10,000		N$ 750	D D M M Y Y	N$ 22,000		N$ 1,650	D D M M Y Y
N$ 12,000		N$ 900	D D M M Y Y	N$ 25,000		N$ 1,875	D D M M Y Y

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, 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 is fully underwritten by a registered insurer, as required by the Medical Aid and Insurance Acts.

Please mark with an (X) if cover is required.		Effective Date		Termination Date	
Funeral Standard Policy		D D M M Y Y		D D M M Y Y	
Funeral Select Policy		D D M M Y Y		D D M M Y Y	
Complimed Plus		D D M M Y Y		D D M M Y Y	
Combo (Funeral Cover / Complimed Plus / Hospicash)		D D M M Y Y		D D M M Y Y	

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Section D - Declaration by Principal Member

I, the undersigned, understand that the Benefit Builders are pro-rated for the period from the effective date up to 31 December. I further declare that the information submitted is true and correct.

Signed at		on this		day of		2	0		
Print Applicant Name									
Applicant/Principal Member signature									

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 E - Funeral Beneficiary *(The beneficiary who will be paid the benefit in the event of a death.)*

Name	Surname	I.D. / Passport Number	Relationship

Section F - Bank Details *(For Debit Order Premiums or EFT Claim Refunds) (Attach proof of bank account details)*

IMPORTANT NOTICE: It is compulsory to supply Prosperity Health with this information. (In the event that refunds should be deposited into a different bank account, attach details as well.)				Effective Date	D	D	M	M	Y	Y	Y	Y
Claims Refund												
Contribution Payments via Debit Order Date		1st of every month		26th of every month								
Name of Account Holder												
Bank Name				Bank Branch Name								
Account Number				Bank Branch Code								
Type of Account	Cheque / Current		Savings	Signature of Account Holder								

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

Namibian Citizen	Yes		No		
Proof of banking details (Please attach confirmation from the bank)		Payslip for options Primary Care, Vital Care and Econo Care			

Section H - Employer Warranty

Compulsory for members belonging to Group Schemes.

Name of Company		Date	D	D	M	M	Y	Y	Y	Y
Management Representation		Company Stamp							
Name									
Designation									
Signature of Company Representative									