MEMBERSHIP BENEFICIARY REGISTRATION FORM

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RMA Renaissance Health Medical Aid Fund — Your Health Comes First

For Office Use Only

									D	D	M	M	Y	Y	Y	Y
Intermediary Information (Broker Number)								Processed by	Date							

Administrator Notes:	Approved by:
1	
2	
3	
4	
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Section A - Principal Applicant Details

Member Number																
Title		Initials			Full Names											
Surname																
Physical Address																
Postal Address												Postal code				
Telephone Number	H	Code					W	Code								
Cellphone Number								Fax Number								
E-mail Address																
Date of Birth	D	D	M	M	Y	Y	Y	Y	Age		I.D./Passport Number					
Marital Status	Single		Married		Divorced		Widowed		Common Law							
Proposed Date of Joining	0	1	M	M	Y	Y	Y	Y								

Section B - Employment Details *(Please tick appropriate box / Compulsory for members belonging to an Employer Group)*

Private		Company		CB Number												
Company Name																
Telephone Number																
Company Postal Address																
Employee Number									Employment Date	D	D	M	M	Y	Y	Y	Y
Designation of Employee																
Management Representation									Date	D	D	M	M	Y	Y	Y	Y
Name									Company Stamp								
Designation																	
Signature of Company Representative																	

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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					
Marriage certificate when registering a spouse / ID / Passport of spouse			Medical certificate for mentally/physically disabled children over 21		

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 F - Medical History

Supply full details on questions below. Where an answer to a question is "Yes", please provide details in the space provided below.
Questions pertain to Applicant and **ALL BENEFICIARIES**.

			Answer	
Non-disclosure of information may result in termination of membership or non-payment of some medical treatment. Have you / your spouse or any one of your beneficiaries ever experienced any of the following? **Please mark (X) the relevant box.**			**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, turbeculosis(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(nephretomy), kidney stones, abnormal kidney or urine tests or any other kidney problems.		
4	Reproductive & Gynae	Endometriosis, infertility, ovaria 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 clitis, gall bladder problems, liver problems or any other digestive problems. Obesity.		
6	Ear, Nose & 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, renita detachment, impaired vision, or any other eyesight problems.		
9	Endocrine	Diabetes mellitus 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 & 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 scelerosis, mental retardation, narcolepsy, motor neuron disease,parkinson's disease, alzheimer's disease, or any other neurological problems.		
12	Psychological	Depression, anxiety, psychosis, suicide attempts, biopolar 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 & Growths	Benign or malignant growths or lumps or tumours including melanomia, 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, dermatomyositis, psoriasis, scleroderma, or any other skin disorders.		
16	Sexually Transmitted Disease	Advice, treatments or counselling for any of the following: HIV/AIDS, syphilis, gonorrhoea, herpes, genital ulcers, pelvic infectious disease, genital warts, hepatisis B or any other sexually transmitted disease or disorder.		
17	Hospitalisation	Have you, your spouse or any dependants ever been hospitalised? If yes, provide information below.		
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 (yyy/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.

Section G - Exclusions

In accordance with the registered Rules of the Fund, a general waiting period of three (3) months and nine (9) month exclusion for confinement and or a twelve (12) month exclusion on any other pre-existing condition may apply where an applicant does not qualify as a continuation member. The applicant hereby acknowledges understanding of the Fund Rules and agrees to the applicable waiting period(s) and exclusion(s) that may be imposed.

Signature of applicant	

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 completed 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	I 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 *mutatis mutandis* 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		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 service 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.