MEMBERSHIP APPLICATION FORM

Tel: +264 83 2999 736
E-mail copy of completed form to: rhmafmember@prosperitynam.com

RMA Renaissance Health Medical Aid Fund — Your Health Comes First

Membership Number	Processed by/Date	Representative Information (Representative Number)

Administrator Notes:	Approved by:
1	
2	
3	

Section A - Principal Applicant Details

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																	

Section C - Bank Details *(For Debit Order Contributions or EFT 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 bank account, attach details as well.)

Claims Refund							
Contribution Payments via Debit Order Date		1st of every month		26th of every month			
Name of Account Holder							
Bank Name				Bank Branch Code			
Account Number				Signature of Account Holder			
Type of Account	Cheque / Current		Savings				

Section D - Beneficiaries to be Covered

I.D. / Passport no.	First Name	Surname	Relationship	Gender		Date of Birth					
				F	M	D D	M M	Y Y
				F	M	D D	M M	Y Y
				F	M	D D	M M	Y Y
				F	M	D D	M M	Y Y
				F	M	D D	M M	Y Y
				F	M	D D	M M	Y Y

Section E - Product Option Selection

Main Product

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.

Benefit Builders

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 RMA Product Options:
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				

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						

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 - Previous Medical Membership

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

Name of previous Medical Aid Fund/s																			
Membership Number								Date Joined								Date Resigned							
								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

Section G - 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**.

		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.**	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(nephretomy), 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 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 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, 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 H - 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 I - 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 applicant			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				

Section J - 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 ("RMA") 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 RMA in respect of benefits for which I have applied. Neither RMA 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 RMA 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/RMA 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 RMA, I additionally authorise RMA/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 RMA 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 RMA 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 RMA.
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 K - 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 L - Addendum

RMA 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 RMA 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.

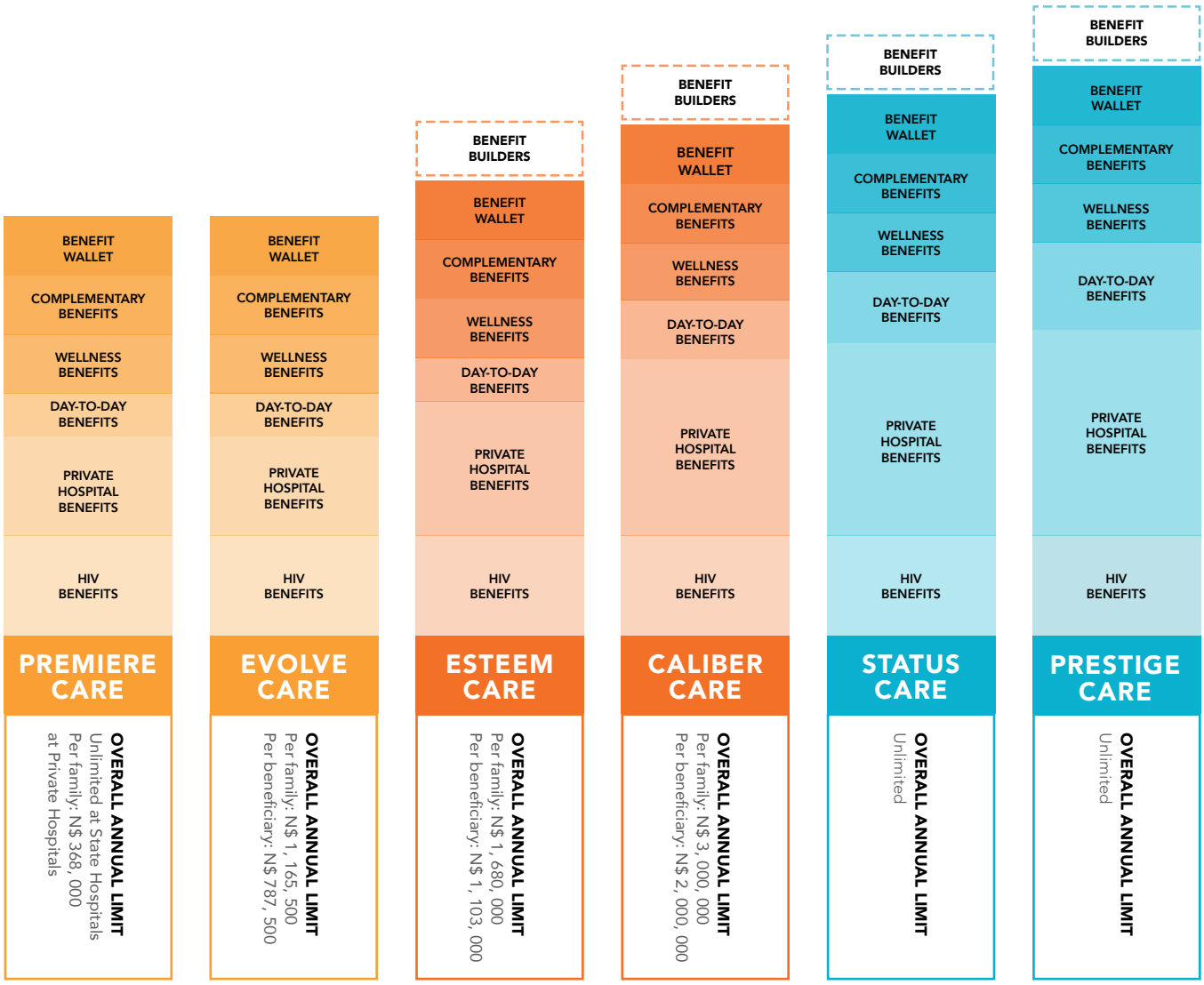
5. It may be required that you be requested to provide additional information or undergo medical testing in order to ensure the processing of your application, if this is required you will be duly informed.

Section M - Representative Endorsement

1. The applicant was in fact assisted in person/telephonically by the Representative.		2. The applicant was given a thorough understanding of the product and the benefits applicable.								
3. The applicant was asked to declare any previous treatment received in the last 24 months prior to joining date.		4. The applicant understands that exclusions and waiting period may be imposed by the Administrator on behalf of RMA even if found to be pre-existing conditions that were not declared upon joining.								
5. The applicant understand that treatment may be declined for pre-exiting conditions for which treatment was received within 24 months prior to joining where such conditions were not declared upon application.										
Representative Signature		Date	D	D	M	M	Y	Y	Y	Y

PRODUCT OPTIONS

RMA
Renaissance Health
Medical Aid Fund
Your Health Comes First



YOUR PRODUCT OPTION REVOLVES AROUND YOUR HEALTHCARE NEEDS. SO IT IS IMPORTANT THAT YOU BECOME FAMILIAR WITH YOUR OPTION.

Choose a Product that will fulfill the healthcare needs of you and your family at a monthly contribution that you can afford. Renaissance Health offers a range of Product Options from Elite Care, that provides the most comprehensive cover, to Premiere Care, that provides for primary healthcare. Each Option has been tailored to cater for specific healthcare needs and your benefits are determined by the Option that you choose. Therefore you need to assess your healthcare needs and become familiar with the benefits available to you by paging through the brochure.

INCLUSIVE BENEFITS IN PRODUCT OPTIONS.

The following benefits are inclusive benefits in the Renaissance Options: Emergency evacuation, Repatriation, Premium protection (should the Principal Member die, the monthly contribution may be covered for three months), International travel insurance cover and SADC medical emergency evacuation, and a Benefit Wallet. Renaissance provides comprehensive cover to its members.

WELLNESS MANAGEMENT BENEFITS - PREVENTION IS BETTER THAN CURE.

Many illnesses and problematic conditions can be prevented and treated before they become a serious health risk. We advocate that prevention is better than cure and have provided for extensive wellness benefits to determine health risks that we will actively manage. Find out more about your Wellness Management Benefits on each Product page of the brochure.

SHOULD YOU NEED MORE BENEFITS DURING THE YEAR.

In that case, Benefit Builders are your answer. Refer to page 30 of the brochure on Benefit Builders to find out how you can top up your benefits during the year should you require additional benefits during a specific year. (What you don't use – you won't lose - we may transfer 80% of the unused Benefit Builder benefits to your Benefit Wallet in the following year).

SHOULD YOU NEED TO MAKE CHANGES TO YOUR PRODUCT OPTION.

If you need more benefits or less benefits, you have the opportunity to change your Product Option in December of every year. Speak to your HR manager, visit one of our offices or visit our website at www.rhmaf.com to obtain an Option Transfer form.

QUESTIONS & ANSWERS

FREQUENTLY ASKED QUESTIONS

When can I join the Fund?

Membership to the Fund is effective from the first day of the month. Applications should preferably be received 2 weeks prior to the joining date to go through the approval process. If application is only received during the month of joining (e.g. the 10th of January for 1st of January) an arrangement should be made on how outstanding payment will be settled since premiums are payable one month in advance.

What does prorated benefits mean?

As the Fund's benefit year is from 1 January to 31 December, any member who joins during the benefit year may receive prorated pro-rated at joining and on termination. That means that your annual limits on benefits may be calculated according to the number of months left in the benefit year. For example, if you join halfway through the year i.e. 1 June, and the dental benefit is N$3000.00 for the year, then you only have seven (7) months benefit starting from June to December which gives you N$1750.00 benefit until 31 December. All benefits are pro-rated

When can I change my benefit option?

Members are given the opportunity to change benefit options once annually, effective as from the 1st of January each year. Closing date for all option changes is the 31st of January and may be effective as from the 1st of January. Contributions will be adjusted as per product change to compensate for any cover or under payments during the month of January.

What are pre-existing conditions?

A pre–existing condition is any medical related condition and/ or symptoms for which treatment was received prior to joining with long term consequences. A 12-month exclusion period may be placed on such conditions, meaning that all costs incurred on any related symptoms and/ or treatment will not be covered during this period.

What are co-payments and how can you prevent it?

Co-payments are the difference between the amount claimed by your Health Care Provider (doctor, specialist, dentist, hospitals etc.) and what your Medical Aid Fund pays. The Medical Aid pays 100% of the NAMAF (Namibian Association of Medical Aid Funds) rates. Members can avoid co-payments by visiting or making use of Service Providers who charge NAMAF tariffs.

CLAIMS INFORMATION

When should you submit claims?

All claims should be submitted within four (4) months from the date on which the service was rendered, otherwise you may lose your right to payment in respect of these claims.

Do I receive immediate cover if I join the Fund and can I claim immediately?

There may be a waiting period of 3 months before you are covered for full benefits. A waiting period may usually apply if you were not a member of a registered medical aid fund for at least two years previously, and the break in membership between leaving your previous fund and joining Renaissance Health is more than three months.

Am I covered while travelling abroad?

All members have access to International Travel Cover, underwritten by Hollard Insurance, which is included in your medical aid option. Members may contact client services for more information and assistance.

BENEFIT TIPS

Use your benefits wisely

As the new year begins medical aid members start with a clean slate, with new benefits.

If you manage your medical expenses correctly, you can avoid out-of-pocket expenses and limit the possibility of running out of benefits.

ASK YOUR PHARMACIST

Buy over-the-counter medicine to treat less serious conditions and consider using generic medicine which is cheaper but effective.

BEFORE HOSPITAL ADMISSION, ASK YOUR DOCTOR

Ask your doctor what your out of pocket expense will be and what your medical aid will cover. If your out of pocket expense is too high, don't be afraid to ask your doctor to adjust their fee or payment schedule.

GET PRE-AUTHORISATION FOR PROCEDURES

Obtain pre-authorisation from the Fund before procedures or hospital admission.

MANAGED CARE BENEFITS

If you suffer from a chronic condition such diabetes, high blood pressure or HIV/AIDS Renaissance offers a disease manage programme which includes a chronic adherence monitoring for our members. Register on the relevant chronic management programmes, the programme is there to help our members to use their benefits to maximum advantage.

PREVENTATIVE SCREENING

Go for your annual preventative screening tests that are covered by the Fund, prevention is better than a cure. Members get rewarded via the benefit wallet for doing so.