nammed
MEDICAL AID FUND

Application Form

Application document checklist
Please ensure you have all the following documents attached:

- ◯ ID/Passport
- ◯ Full Birth Certificate
- ◯ Proof of Study
- ◯ Marriage Certificate or Declaration of Common Law Spouse

For office use

Phone +264 61 374 600
Email nammed@paramount.com.na info@nammed.org.na
Web www.nammed.info www.nammed.com.na
Address 1 John Ludwig str, Klein Windhoek

Please complete all applicable sections in full

A. BENEFIT OPTION

◯ Comprehensive ◯ Standard ◯ Essential ◯ Trauma ◯ Active ◯ Basic (please provide recent payslip)

B. APPLICANT'S PARTICULARS

1. PERSONAL DETAILS

Title: Prof | Dr | Mr | Mrs | Miss

Surname

First names

Initials | Sex: M F | Date of birth: D D / M M / Y Y Y Y

Marital status | ID/Passport

Employer | Occupation

Email address

Tel: W ( ) | H ( )

Mobile | Preferred language: Afrikaans ◯ English ◯

I would like to receive communication via ◯ Email ◯ SMS ◯ Post

Postal address	Physical address

FOR OFFICE USE ONLY

Underwriting decisions

Waiting period: Y N | Exclusions: Y N

Other exclusions:

Membership no	Option

Active date: D D / M M / Y Y Y Y

D/O ◯ EFT ◯ Group ◯ Individual ◯

Contribution	Mode of payment

Date processed: D D / M M / Y Y Y Y

Loaded by	Approved by	Control officer

2. CURRENT MEDICAL AID MEMBERSHIP STATUS

For the past two years uninterruptedly, were you or your dependants members of a registered medical aid fund | Y | N |

If YES please provide the membership certificate of your current medical aid fund
Potential members are advised not to resign from their current medical aid before application has been approved

Name of medical aid fund | | Option | |

Active membership from | D | D | / | M | M | / | Y | Y | Y | Y | To | D | D | / | M | M | / | Y | Y | Y | Y |

Was the membership subjedct to any exclusions? | Y | N |

If YES provide detals below

C. ABOUT YOUR DEPENDANTS

Dependants are your spouse, children under 21 years of age, unmarried and not in full time employment. Full time students at a recognised educational institution, up to the age of 25 years may be included (proof of registration required)

Dependant	Full name	Surname	Sex M/F	Date of birth	ID/Passport no
Spouse					
1st child					
2nd child					
3rd child					
4th child					
5th child					
Adult Dependant 1					
Adult Dependant 2					

Should you be applying for more than 6 dependants, please attach a list

D. CURRENT STATE OF HEALTH

1. Are you now pregnant? | Y | N | If so, how many months? | | | Name of expecting mother | |

2. Have you or any of your dependants ever suffered from any of the following? If "Yes", provide full particulars in 9 below.

2.1	Any disorder of the heart, e.g. rheumatic fever, heart murmur, coronary artery disease, chest pain, shortness of breath or palpitations?	Y	N
2.2	High blood pressure or disease of the blood vessels or circulatory disorder?	Y	N
2.3	Any respiratory or lung trouble, e.g. asthma, bronchitis, persistent cough, tuberculosis?	Y	N
2.4	Any disorder of the digestive system, gall bladder or liver, e.g. actual or suspected gastric or duodenal ulcer, recurrent indigestion or hiatus hernia?	Y	N
2.5	Disease or disorder of kidneys, bladder or reproductive organs, e.g. albumin in urine, kidney stones, prostatitis, pancreatitis or venereal disease?	Y	N
2.6	Any nervous or mental complaint, e.g. epilepsy, black-outs, paralysis, anxiety state or depression?	Y	N
2.7	Ear, eye, nose or throat disorder, e.g. ear discharge, defective vision, recurrent tonsillitis?	Y	N
2.8	Disorder or disease of muscles, bones, joints, limbs, spine, e.g. rheumatism, arthritis, gout, slipped disc or other back trouble?	Y	N
2.9	Diabetes, sugar in urine, thyroid or other glandular or blood disorder?	Y	N
2.10	Cancer, growth or tumor of any kind?	Y	N
2.11	Any tropical disease, e.g. bilharzia?	Y	N
2.12	Any other illness, disorder, disability or accident which required medical, radiological, surgical or pathological investigations during the past 3 years?	Y	N
2.13	Received or expect to receive any medical advice, counselling, treatment or blood test in connection with AIDS or an AIDS-related condition?	Y	N
3.	Do you or any of your dependants have any physical (including dental) abnormality, deformity, handicap or defect, whether congenital or as a result of an accident, disease or some other cause? If “Yes”, please provide full particulars in 9 below.	Y	N
4.	Do you or any of your dependants suffer from any ailment or disease at present? If “Yes”, please provide full particulars in 9 below.	Y	N

5.	Are there, in respect of you or any of your dependants, any other circumstances not mentioned elsewhere in this declaration/ questionnaire, relating to past or present diseases, accidents, operations or other conditions including pregnancy for which advice has been sought or treatment has been received or recommended during the past 5 years? If "Yes", please provide full particulars in 9 below.	Y	N
6.	Are you or your dependants expecting to undergo any procedure, operation, confinement or receive any major dental treatment during the next 12 months?	Y	N
7.	Length and Weight of PM _____cm _____kg Length & Weight of AD 1 _____cm _____kg Length & Weight of AD 2 _____cm _____kg Length & Weight of AD 3 _____ cm _____kg		
8.	Do you or any of your dependants currently use chronic medication? If yes please list the medication below	Y	N
9.	PARTICULARS REQUIRED IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS (A MEDICAL CERTIFICATE MAY BE REQUESTED TO EVALUATE CONDITION AND FUTURE TREATMENT)		

Nr	Name of patient	Illness	Date and nature of treatment	Facility/DR	Follow up needed

E. CERTIFICATE BY EMPLOYER: Applicable to employees registering on their groups

Employer Name		Employer Address	
Contact person			
Contact no		Email Address	
Payroll number		Date of employment	D D / M M / Y Y Y Y

F. STATEMENT BY THE APPLICANT, TERMS AND CONDITIONS

I, the undersigned, apply for the membership of Nammed Medical Aid Fund and agree that all answers and information contained in this application and all documents which, in Nammed's opinion are relevant to the risk and which are signed or will be signed by me, shall be the basis of my membership and that they shall be warranted as true and complete; and my membership shall be void if any information should be inaccurate or incomplete, in which event all the money paid towards the membership shall be forfeited to Nammed and all benefits paid shall immediately be payable to Nammed.

My membership shall not commence unless Nammed specifically notifies me in writing of their acceptance of the risk and any deterioration or change op my state of health or the health of my dependants before the due date or the occurrence set by Nammed for the commencement of the membership or the date on which this application was accepted by Nammed or the date of the first contribution, whichever is the latest date, shall give Nammed the right to reconsider the application and propose new terms of acceptance or to declare the membership a null and void in which event all the money paid towards membership before Nammed receives notice of such change shall be forfeited to Nammed and benefits paid shall immediately be payable to Nammed. I hereby agree to abide by the rules of Nammed as required by Act 23 of 1995 and approved by NAMFISA.

I irrevocably give my consent to my medical doctor, person or organisation, who may possess, or may come into possession of any information regarding my health or the health of my dependants, to disclose this information to Nammed.

I give my consent to my employer in the case of group membership to deduct from my salary and pay Nammed all amounts that may be due to Nammed

SIGNED AT _____ ON THIS _____ DAY OF _____ 20H _____

SIGNATURE OF APPLICANT _____ WITNESS _____

G. METHOD OF PAYMENT

◯ EFT ◯ DEBIT ORDER

H. BANK ACCOUNT DETAILS FOR DEBIT ORDER

Name of account holder			
Account number		Branch code	
Name of bank		Type of account	

We request that Nammed Medical Aid Fund make the necessary arrangements with my/our bank according to the debit order system to collect the subscription fees according to the rules of Nammed Medical Aid Fund (as amended from time to time). Arrear contributions/amounts (where applicable and debt repayments (where requested) in connection with my application against my/our account wherever such account is kept. I, we agree to pay any expense concerning this debit order, and understand that all drawings, hereby authorised, will be printed on my/our bank statement or accompanying slip. This authorisation can be cancelled by me/us by giving 30 days' notice. I/we understand that I/we are not entitled to any repayment of any amount which was drawn while the authorisation was effective, If such amounts were legally due to Nammed Medical Aid Fund, The receipt of this instruction by you will act as acceptance by my/our bank.

I undertake to notify Nammed Medical Aid Fund of any change in respect of my address or Bank.

SIGNED AT	ON THIS	DAY OF	20H
SIGNATURE OF APPLICANT		WITNESS	

I. BANK ACCOUNT DETAILS FOR REFUNDS

Name of account holder			
Account number		Branch code	
Name of bank		Type of account	