

Add Dependant Form

DEAR MEMBER											For office use														
Should you wish to add any dependant (spouse, adult dependant and/or child(ren), older than 1 month) to your membership, kindly complete the questionnaire below and please attach copies of the dependant('s)																									
(Id or Birth Certificate or Passport										Phone +264 61 374 600														
Marriage Certificate										Email			info@nammed.org.na												
											/eb		www.nammed.com.na												
										-	Address			1 John Ludwig str, Klein Windhoek											
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			I					I	ı	ı	ı						I	I	ı	I		I			
Name and surname of dependant																									
	Date of birth	D	D	/	М	М	/	Υ	Υ	Υ	Υ			Join date											
N	ammed membership number] :			D	D	/	М	М	/	Υ	Υ	Υ	Υ
	Current medical aid fund												_												
	carrette medical did faria																								
1.	Is above dependent prognant at present? If so, how many months?														Υ	N									
2.	Is above dependant pregnant at present? If so, how many months? Has the dependant ever suffered from any of the following? Months Y N														14										
2.1	Any disorder of the heart, e.g. rheumatic fever, heart murmur, coronary artery disease, chect pain shortness of breath or													Υ	N										
2.2															Υ	N									
2.3	Any respiratory or lung trouble, e.g. asthma, bronchitis, persistent cough, tuberculosis?														Υ	N									
2.4	Any disorder of the digestive s	yster	n, ga	all bla	dder	or li	ver,	e.g. a	ctua	lors	uspe	cted	l gas	tric c	or duc	den	al ulc	er, re	ecurr	ent i	ndig	estio	n	Υ	N
2.5	or hiatus hernia? Disease or disorder of kidneys, bladder or reproductive organs, e.g. albumin in urine, kidney stones, prostatitis, pancreatitis or venereal disease?														Υ	N									
2.6	Any nervous or mental complaint, e.g. epilepsy, black-outs, paralysis, anxiety or depression?														Υ	Ν									
2.7	7 Ear, eye, nose or throat disorder, e.g. ear discharge, defective vision, recurrent tonsillitis?														Υ	Ν									
2.8	.8 Disorder or disease of muscles, bones, joints, limbs, spine, e.g. rheumatism, arthritis, gout, slipped disc or other back trouble?														Υ	Ν									
2.9	.9 Diabetes, sugar in urine, thyroid or other glandular or blood disorder?															Υ	N								
2.10	.10 Cancer, growth or tumour of any kind?															Υ	N								
2.11	11 Any tropical disease, e.g. bilharzia?														Υ	Ν									
2.12	Any other illness, disorder, disathe past 3 years?	ability	y or a	accide	ent v	vhich	req	uirec	d me	dical	, radi	olog	ical,	surg	ical o	r pat	holo	gical	inve	stiga	tions	duri	ing	Υ	N
2.13	Received or expect to receive a condition?	any n	nedi	cal ac	lvice	, cou	nsel	ing, t	reati	ment	t or b	lood	test	in c	onne	ction	with	AID	Sora	an Al	DS-r	elate	d	Υ	N
3.	Does the dependant have any result of an accident, disease of						tal)	abno	rmal	ity, d	lefori	nity,	han	ıdica	p or d	efec	t, wh	ethe	r con	igeni	tal o	r as		Υ	N
4.	Does the dependant suffer fro	m an	ny ail	ment	or d	liseas	se at	pres	ent?															Υ	Ν
5.	Are there any other circumstal accidents, operations or other or recommended during the particles.	conc	litior	ns inc																				Υ	N
6.		or recommended during the past 5 years? Is the dependant expecting to undergo any procedure, operation, confinement or receive any major dental treatment during the next 12 months?												Υ	N										

If you answered "YES" to one or more of the above questions please provide us with:

- a letter from a General Practitioner or Specialist which shall include the following information:
- Name of patient, illness and/or condition and the date when treatment was received.
- If future treatment is recommended, the likely date and duration of treatment have to be specified.

Principal Member	Date	D	D	/	М	М	/	Υ	Υ	Υ	,