HERITAGE HEALTH
We care about your health

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A. Membership Application Form

	Prof	Hon	Dr	Mr	Mrs	Ms	Other
Title:							

Surname

First Names

Personal Postal Address

Tel Code and Number

Fax Code and Number

Cell Phone Number

Email Address

Date of Birth D D M M Y Y Y Y

Gender Male Female

ID/Passport Number

Marital Status Married Single Widowed Divorced

B. Benefit Option

Please Note: *Your benefit plan already includes Emergency Evacuation/Ambulatory Services; Travel Insurance and Funeral Benefits. Please mark your option(s) with ✔ in the appropriate box.*

In Hospital Options:

- *Baobab N$ 2 700 000*
- Acacia N$ 1 450 000
- Kiaat N$ 700 000

All Hospital Plans includes Chronic Medication, Oncology, Specialised Radiology and Doctors on Call

Optional Day-to-Day Options:

- Super N$ 50 000
- Standard N$ 30 000

Fixed Benefit Options:

- Camelthorn Comprehensive Plan Hospital Unlimited and Unlimited
- Maroela Comprehensive Plan Hospital N$ 1,500,000 and Day-to-Day N$ 26 000
- Hoodia Comprehensive Plan Hospital N$ 320 000 and Day-to-Day N$ 17 000

C. Employment Details (*Information must always be completed by the Main Member)*

Employer Name

Will Employer Pay Monthly Contributions Y N

Employment Date D D M M Y Y Y Y

Eligible Start Date of Cover D D M M Y Y Y Y

Employer Address

Employer Tel Number (..... .)

Employer Fax Number (.....)

Signature of Company Official .....,,,,,.....

D. Family Members to be Covered

(Please note that only *legal* beneficiaries may be registered.) Documentary proof is required for example birth certificate, marriage certificate, mortality certificate) *CHILDREN ABOVE 18 MUST INCLUDE PROOF OF FULL TIME STUDENT*

	Full Names and Surname	M/F	Date of Birth
Spouse/Partner			D D M M Y Y
Child 1			D D M M Y Y
Child 2			D D M M Y Y
Child 3			D D M M Y Y
Child 4			D D M M Y Y
Child 5			D D M M Y Y

E. Notice to Add New Dependant

(Information must only be completed by the Main Member for the Registration of a New Dependant) Attach proof of marriage certificate, birth, legal appointment etc. Must complete Section H for any new dependant

Full Names and Surname	Date of Birth	Relationship	Nature of Change
	D D M M Y Y		
	D D M M Y Y		
	D D M M Y Y		

Effective Date of Change D D M M Y Y Y Y

F. Notice to Remove Dependant

(Information must only be completed by the Main Member)

Full Names and Surname	Date of Birth	Relationship	Nature of Change
	D D M M Y Y		
	D D M M Y Y		

Effective Date of Termination D D M M Y Y Y Y

G. Previous Medical Aid History

Please Note: ***Kindly attach a copy of the certificate of termination from the previous medical aid, if applicable.***

Provide claim history of past medical aid scheme

Have you, as the main member, or any of your dependants had medical aid cover Y N

If "YES" please confirm from when to when D D M M Y Y Y Y to D D M M Y Y Y Y

Have any waiting periods, exclusions or any other penalties been imposed on any previous cover for you, or any of your dependants? Y N

If "YES" please provide the details in the below

Name of beneficiary	Name of Fund	Reason or Condition for waiting period/exclusion/penalty

H. Health Information: ***To be completed by all applicants. Please place a tick in the relevant box. Detail on next page.***

Have you or any named dependant ***ever suffered from*** or been ***treated*** for any of the ***following or relating conditions***?

1. High cholesterol, stroke, high blood pressure, heart murmur, angina/chest pain, heart attack, coronary artery disease, shortness of breath, congenital heart disorder or any blood disorder? Y N
2. Nephritis, kidney stone, congenital kidney disorders, blood in urine, kidney or bladder infections, removal of kidney stones or any other urinary or related kidney disorder or treatment? Y N
3. Difficulty in breathing, persistent cough, tuberculosis (TB), asthma, bronchitis, croup, emphysema, pneumonia, cystic fibrosis, or any other respiratory related disorder. DO YOU SMOKE? Y N
4. Conditions of the joints or spine, including rheumatism, arthritis, neck or back disorders, or any other bone or skeletal disorders or any physical disability? Y N
5. Diabetes, thyroid problems, crushing's syndrome, addison's disease, pituitary gland, sugar in the blood or urine or any other glandular disorders? Y N
6. Any lumps or growths, benign or malignant, types of cancers, including Hodgkin's or Leukaemia, skin cancer etc? Y N
7. Epilepsy, migraine, stroke or any other neurological disorder for which treatment was/is received? Y N
8. Ulcers, hiatus hernia, gall bladder or liver disorders or any other digestive system disorder? Y N
9. Any gynaecological conditions/symptoms including infertility/miscarriages, ovarian cysts, breast biopsies, prostate infections, prostate enlargement or any other reproductive problems? Y N
10. Advice, counselling, treatment/therapy for alcoholism, drug dependency, mental or emotional disorders, stress/depression, attention deficit disorder or any other psychological conditions? Y N
11. Medical advice, counselling or treatment for HIV/AIDS or any other sexually transmitted disease? Y N
12. Orthodontic treatment, dental surgery, wisdom teeth, cysts or any other dental conditions? Y N
13. Have any of your close family suffered from any hereditary disease for which treatment has been received? Y N
14. Are you or any of your dependants pregnant? If so, what is the expected date of delivery? Y N
15. Impairment of the eyes, cataracts, glaucoma, renitis, pigmentosa or any other eyesight problems? Y N
16. Haemorrhoids or varicose veins? Y N
17. Principal member: Height Weight Spouse: Height Weight

I. If you answered "YES" to any of the questions under "H" please provide the full details below

Please Note: *<u>Failure to disclose medical conditions may limit and/or exclude certain benefits or result in the termination of your medical benefits.</u>* ***Persons over 55 years must submit full medical report and eye reading tests.***

No	Name of Person	Condition/Illness	Date of Treatment	Name of Doctor	Duration of Treatment
			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		
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			D D M M Y Y Y Y		
			D D M M Y Y Y Y		

J. Chronic Medication

<u>Please Note:</u> If you or any of your dependants take any form of medication on a regular basis you need to disclose it in the below table. ***You must submit a copy of the latest prescription to enable dispensing*.** To register new chronic conditions after becoming a member you need to complete the prescribed form and register the applicable medication and provide a copy of a valid prescription. ***VALID AND REGISTERED CHRONIC MEDICATION COVERED IMMEDIATELY***

Name of Person	Name of Condition	Name of Medication	Duration of Medication
			D D M M Y Y Y Y **TO** D D M M Y Y Y Y
			D D M M Y Y Y Y **TO** D D M M Y Y Y Y
			D D M M Y Y Y Y **TO** D D M M Y Y Y Y
			D D M M Y Y Y Y **TO** D D M M Y Y Y Y
			D D M M Y Y Y Y **TO** D D M M Y Y Y Y
			D D M M Y Y Y Y **TO** D D M M Y Y Y Y
			D D M M Y Y Y Y **TO** D D M M Y Y Y Y
			D D M M Y Y Y Y **TO** D D M M Y Y Y Y
			D D M M Y Y Y Y **TO** D D M M Y Y Y Y
			D D M M Y Y Y Y **TO** D D M M Y Y Y Y

K. Banking Details

Please Note: ***Your banking details are required for reimbursements on claims and or debit order deductions. You must attach a cancelled cheque as proof of banking details and a copy of the Identification document of the account holder***.

Use this account for Monthly Contribution deduction and any Claims' Refunds ☐
Use this account for monthly contribution only ☐

Use this account for Claim Refunds Only ☐

Bank Name	
Branch Name	
Name of Account Holder	
Bank Account Number	
Branch Code	
Type of Account	Cheque / Transmission / Savings
Total Monthly Contribution	
Date Cover Commences	D… D M M Y Y Y Y

Bank Name	
Branch Name	
Name of Account Holder	
Bank Account Number	
Branch Code	
Type of Account	Cheque / Transmission / Savings

I hereby instruct the administrator to electronically collect monthly contributions and to deposit claim refunds via electronic banking facilities to the above stated banking details. I understand and accept that no transfers can be undertaken from credit card accounts and that no post office savings accounts are allowed. I further authorise Heritage Health to increase the monthly contribution due in terms of the conditions of the Fund. I also authorise the administrator to adjust any incorrect transactions and/or correct any electronic transfers.

I agree that I am not entitled to recover any amount drawn from my account by means of this debit order. This authorisation is to remain in force until cancelled by me by giving 30-days written notice to Heritage Health. If my debit order is declined as a result of insufficient funds and I fail to pay by the outstanding amount by the seventh day of the month I accept that my benefits will be put on hold. Three consecutive non-payments results in automated termination of membership of the Fund

I undertake to notify Heritage Health of any amendments in respect of my banking details.

D… D M M Y Y Y Y

_____ _____

Name of Account Holder *Signature of Account Holder*

PLEASE NOTE: ***Should the total amount on the application form differ from the payable amount in terms of the Policy and your preference the system will automatically deduct the correct amount***

L. Declaration and Acknowledgement

1. I acknowledge having read and I understand the ***significance of the importance of the correct completion of the information requested*** in this application form pertaining to me and my dependants. ***I declare all entries made on this form to be true and correct and that I am not aware of any circumstances which might affect the risk on my health or any of my dependants.*** Should there be any non-disclosure or misrepresentation, I understand and accept that my membership may be terminated and that I may forfeit my contributions. Heritage Health has the right to claim any costs incurred in respect of my non-disclosure or misrepresentation.

2. Should any of mine or my dependant(s) circumstances alter subsequent to the date of filling in this application, prior to or after the acceptance of my membership by Heritage Health, I undertake to notify the Fund immediately. I acknowledge that failure to do so may lead to the termination or amendment of the terms and conditions of my membership.

3. I understand and agree that it is my responsibility to ensure the monthly contribution to be paid for my membership by no later than the seventh day of each month upfront (in advance) whether such payment is undertaken by debit order or by my employer or any other person who pays on my behalf. I accept that failing to pay the applicable monthly contribution will result in the suspension of all benefits. Failing to pay for contributions for three consecutive months will automatically terminate my cover.

4. I authorise the obtaining of any personal medical information for me or any of my dependants from a treating physician who has attended or examines me or my dependants and which may be required in respect of this application or any future claims submitted by me.

5. I authorise and permit the Fund to take all reasonable steps to verify the information provided by me in this application form.

6. I understand and accept that this declaration and my application form constitute the basis of my contract with Heritage Health. No oral representations, inducement, statements or promises by or on behalf of any party, and not contained in the application form shall be relied upon.

7. I agree to be bound by the terms and conditions of cover under Heritage Health.

8. I hereby consent that all my contact details may be used by Heritage Health for the distribution of information.

9. I agree that any payment accompanying the application shall be a deposit only and I understand that any cover will only commence once I receive the membership card and any conditions pertaining to the cover.

Signed at _____ on this _____ day of _____20_____

_____
Signature of main member

Company Stamp

(where applicable)

Check List

*Please Note: To enable Heritage Health to deliver an efficient service to you, it is important that you **provide and complete all information as required.** Your application form cannot be processed if it is incomplete, incorrect or if you have failed to attach the correct requested documents.*

ID/Passport of main member	☐	Copy of marriage certificate when registering your spouse	☐
ID/Passport of spouse	☐	Birth certificates of children	☐
Proof of cover of previous medical aid	☐	Copy of valid chronic medication prescription	☐
Sign the Declaration and Acknowledgement	☐	Provide medical report and eye tests where applicable	☐

1. The application must be completed in full and all information required must be provided.
2. The date that cover commences is always on the first day of a month.
3. Do not use nick names to register dependants.

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Broker Number	**Accept**	**Decline**	**Group Code**	**Individual**
Member Number **.....**			**Monthly Contribution** **N$_____**	**Benefit Option**
Entry Date	**D**	**D**	**M**	**M**	**Y**	**Y**	**Y**	**Y**

Confinement Period Excluded **Yes ..... No……..**								
Waiting Period								
Three Month Waiting Period	**Yes**	**No**						
<u>Twelve Months</u> **NAME OF BENEFICIARY**	**CONDITION**							
<u>Total exclusions</u> **NAME OF BENEFICIARY**	**CONDITION**							
Control Officer								
Date	**D**	**D**	**M**	**M**	**Y**	**Y**	**Y**	**Y**