MOTOR VEHICLE ACCIDENT / INJURY REPORT

Tel: +264 83 2999 000
E-mail copy of completed form to: HPA@prosperitynam.com

RMA Renaissance Health Medical Aid Fund — Your Health Comes First

Kindly do not use tippex in the completion of this form - kindly initial where corrections have been made and complete accordingly.

CONSENT TO RELEASE PATIENT INFORMATION

(Full name), ID Number		I, the undersigned	

hereby authorise the hospital to provide information concerning my hospitalisation to the medical aid fund, managed health care organisation and their respective agents and employees dealing with my hospitalisation.

I, as the authorised parent / legal guardian of the patient	

hereby authorise the hospital to provide information concerning his/her hospitalisation to the medical aid fund, managed care organisation and their respective agents and employees dealing with my hospitalisation.

Date	D	D	M	M	Y	Y	Y	Y	Signature		Witness	

Section A - Personal Details

Product Option	
Member Number	
Patient's Name	
Principal Member Name	

Section B - In case of an injury or accident, complete this section *(Attach a copy of Police Report)*

Explain briefly why the treatment was necessary / Diagnostic information:	
Where did the accident / injury take place?	

When did the accident / injury happen?	Date	D	D	M	M	Y	Y	Y	Y	Time					
Accident Report (AR) Number															
How did the accident / injury happen?															
*At time of the accident were you a passenger / the driver of the car	*Passenger		*Driver		*Neither										
*Other (Explain)															
Are you covered by a personal / Company accident policy	Yes		No												
If YES, kindly provide details															
MVA Case Number		MVA Registration Date	D	D	M	M	Y	Y	Y	Y					

Section C

Will an attorney act on your behalf?	Yes		No												
Admission Date	D	D	M	M	Y	Y	Y	Y	Discharge Date	D	D	M	M	Y	Y	Y	Y
Hospital Claim Details															
All Other Claims Details															
Authorisation Number															

Administered by PROSPERITY HEALTH

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Section D - Undertaking

I,		the undersigned hereby request the Fund to meet my claims

submitted and/or to be submitted for payment of any benefits in terms of my Medical Aid Fund arising out of the accident / incident as described in the attached document (Annexure A).

I hereby undertake and acknowledge in favour of the Medical Aid Fund that:

1. I shall, to the best of my ability, pursue a claim for compensation against a Third Party responsible for the incident / accident, I may have in terms of the laws of Namibia.
2. Any benefits granted by the Medical Aid Fund which may be recoverable from a Third Party, shall be reimbursed by me to the Medical Aid Fund upon successful conclusion of the claim.
3. I shall supply such information to the Medical Aid Fund as may be requested, in writing, which is relevant to my claims, my financial circumstances and / or the circumstances of the incident / accident.
4. I further hereby authorise any authority , agent or assessor acting on my behalf in respect of my claim to give the Medical Aid Fund any such information as may be required.
5. In the event that I fail to pursue my claim for compensation against any Third Party arising out of this incident / accident, within one year from the date of such incident / accident, I shall be obliged to cede, assign and/or makeover in favour of the Medical Aid Fund all my right, title and interest in and to such claims against such Third Party.
6. I select *domicillum itandi et executandi* for all purposes, in terms of this agreement as set out above. I, undertake that I shall, on fourteen (14) days written notice given by registered post, notify the Fund of any change to address.
7. No relaxation or indulgence granted to me by the Medical Aid Fund shall be deemed to be a waiver in its rights in terms of this undertaking.

Physical Address (Domicillum)										
Full Names of Principal Member										
Signature of Principal Member		Date	D	D	M	M	Y	Y	Y	Y
Full Names of Witness 1										
Signature of Witness 1		Date	D	D	M	M	Y	Y	Y	Y
Full Names of Witness 2										
Signature of Witness 2		Date	D	D	M	M	Y	Y	Y	Y