RMA

Renaissance Health

Medical Aid Fund

MEMBER APPLICATION

FORM

2024

MEMBERSHIP APPLICATION FORM

Tel: +264 83 2999 000
E-mail queries: rmamember@prosperitynam.com

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

RMA
Renaissance Health
Medical Aid Fund

Administrator Notes:	Approved by:
1	
2	

Office Use Only

Screened		Captured		QC		Scanned	
Date		Date		Date		Date	
Signature		Signature		Signature		Signature	

Section A - Principal Member Details

Member Number							
*Source of Income	Salary		Private Business		Other		
*Source of funds, kindly specify							
Title		Initials		Full Names			
Surname							
Previous Names (If any)				Nationality			
Physical Address							
Postal Address				Postal code			
Telephone Number	(H) Code			(W) Code			
Cellphone Number				Fax Number			
I.D/Passport Number				Passport Expiry Date	D D M M Y Y Y Y		
E-mail Address							
Date of Birth	D D M M Y Y Y Y			Age			
Marital Status	Single		Married		Divorced		Widowed		Cohabitation	
Proposed Date of Joining	D D M M Y Y Y Y						

Section B - Employment Details *(Kindly tick appropriate box / compulsory for members belonging to an Employer Group)*

Private		Company		CB Number	
Company Name					
Telephone Number					
Employee Number			Employment Date	D D M M Y Y Y Y	
Management Representation			Date	D D M M Y Y Y Y	
Name			Company Stamp		
Designation					
Authorised Signatory Signature					

Section C - Bank Details *(For Debit Order Contributions or EFT Claim Refunds)*

IMPORTANT NOTICE: It is compulsory to provide RMA with this information. (In the event that refunds should be deposited into a different bank account, attach details as well.) Kindly provide proof of banking details not older than 3 months.

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

Section D - Dependants to be Covered *(Attach copy of ID/s/full birth certificates)*

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

Section E - Product Option Selection *(Effective annually on 1 January)*

Elite Care		Prestige Care		Status Care	
Caliber Care		Esteem Care		Evolve Care	
Premiere Care		Premiere Care - Network			

Benefit Builders

Add / Change		Termination		Termination Date	D	D	M	M	Y	Y

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

Optional Insurance Products:

Underwritten by a registered insurer, Prosperity Lifecare Insurance Ltd.

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 in terms of FIA Legislation

I hereby confirm that information provided to me by the Applicant has been verified in compliance with the FIA Legislation and the identity of the Applicant established.

Financial Intermediary Name		Date	D	D	M	M	Y	Y	Y	Y
Financial Intermediary Signature										

Funeral Beneficiary *(*The beneficiary who will be paid the funeral 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 / Current Medical Aid / Medical Insurance	

Membership / Policy 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

My Spouse is not a member of another fund / scheme							
My Spouse is a member of a registered fund / scheme		If this block is ticked, kindly complete section F below.					
My Spouse is employed at (Name of company)							
Date of marriage/divorce/cohabitation		D	D	M	M	Y	Y

Section G - Medical History

Supply full details on questions below. Where an answer to a question is "Yes", kindly provide comprehensive details in the space provided below.
Questions pertain to Applicant and **ALL Dependants**.

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 dependants ever experienced any of the following? **Kindly 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, turbeculosis(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, ovaria 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 scelerosis, 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, dermatovovsitis, psoriasis, scleroderma, or any other skin disorders.		

Section G - Medical History

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 dependants ever experienced any of the following? **Kindly mark (x) the relevant box.**

			Answer	
			Yes	**No**
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, how frequently.		
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 dependants 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", kindly give a comprehensive 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.

Principal Applicant Signature	

Section I - Documentation *(The following documentation should accompany the application form where applicable:)*

Document		Document	
ID / Passport of main applicant		Birth certificate / proof of guardianship of child / grandchild (full birth certificate)	
Proof of banking details (Kindly attach confirmation from the bank not older than 3 months)		Medical certificate for mentally/physically disabled children over 21	
Payslip or other proof of income		Proof of source of funds	
Marriage certificate when registering a spouse / ID / Passport of spouse / Declaration of cohabitation			

Section J - Declaration by Applicant

In this declaration the singular shall imply the plural.

No.	Declaration
1	I, the undersigned, hereby apply for membership to Renaissance Health Medical Aid Fund ("RMA") on behalf of myself and dependants.
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 or my dependants.
3	I agree on behalf of myself and my dependants, 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 misrepresentation 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 RMA unless express written notice of acceptance of risk is given by the Fund.
5	It is agreed and understood that membership will only commence on the 1st day or the month following receipt of payment by the Fund in favour of RMA in respect of a membership contribution.
6	I irrevocably authorise and provide informed consent on behalf of myself and dependants as the context permits, any medical practitioner, 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 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 to submit my data to requisite associates such as my Medical Practitioner or pharmacist in so far as either myself or my dependants elect to participate in a disease management program.
7	I indemnify RMA and Prosperity Health with 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 RMA to debit my bank account, details of which have been provided for any amount due in terms of the membership applied for.
10	I undertake to advise RMA of any change in the status of health of myself, or any of my dependants, 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 dependants 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 RMA does not extend credit for myself or my dependants whilst being a member of RMA, therefore upon termination of membership of RMA, all outstanding payable credit and interests may be charged on all amounts owing to RMA.
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 RMA may incorporate Insurance products of which the risk is fully underwritten by a registered insurer, Prosperity Lifecare Insurance Ltd in terms of the relevant legislation. The terms and conditions of these products may be obtained from RMA on request.
15	I understand that any changes to this document as well as membership status of any of myself or any of my dependants will require the completion of the necessary forms.
17	I hereby acknowledge that I understand that the product selected has an overall annual limit with applicable sub limits.
18	I understand and agree to all the above:

Signed at		on this		day of		2	0	Y	Y
Principal Name									
Principal Applicant Signature									

Section K - Disclaimer

No.	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

Kindly take note the below details when completing the application form. Kindly 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 kindly feel free to contact the Client Services Department at Tel: +264 83 2999 000 or email: rmamember@prosperitynam.com

1. It is important that the application form be completed in full to ensure that all relevant information is duly considered.
2. We urge potential Applicants to note the importance of the medical history section. In this regard we encourage prospective Applicants to be forthcoming as any omission or misrepresentation of fact may result in termination of membership in compliance with Fund Rules.
3. Where RMA elects to effect restrictions or exclusions on the principal member or any of the dependants, this will be communicated in writing to the principal member for acceptance of the restrictions or exclusions, once signed off by the principal member, the registration process will then be completed.
4. Where a member applies for membership, or adds a dependant, during the course of a benefit year, it is important to note that membership benefits will be pro-rated.
5. It may be required that the principal member or dependants be requested to provide additional information or undergo medical testing in order to ensure the processing of their application, if this is required the principal member will be informed accordingly.
6. The principal member guarantees that the information supplied are true and accurate. This affirmation is extended to any information which in the reasonable opinion of the Fund is relevant to the clinical and financial risk thereof and where it transpired that the information provided by the principal member is incomplete and/or inaccurate, the Fund may cancel membership in compliance with the Fund Rules.
7. The principal member acknowledges that he/she has a right to request a copy of any documentation that is submitted by or on behalf of the principal member to the Fund in as far as same applies to the principal member and any of his/her dependants.
8. In compliance with the Prevention of Organised Crime Act, No 29 of 2004 as amended, the Applicant confirms that the funds that will be utilised for the payment of premiums, in terms of this policy, are and shall continue to be derived from a lawful source. The Applicant additionally avails themselves to provide, upon request, any added clarity or documentation as may be required by the Insurer to ensure the legality of the source of the funds.
9. The principal member herewith consents to the capturing, storage and recording of information as provided electronically or otherwise, the Fund designated system records will constitute the record of this transaction and may be utilised as evidence in a court of law should same be required. The member further consents to the processing and storage of their personal information and in compliance with and for due usage in regard to the purpose for which it is obtained, inclusive of direct marketing, with due cognisance of international best practice in this regard and requisite legislation.
10. The principal member is entitled to provide updates in regard to their personal information, request deletion thereof where relevant and may obtain, upon request, any of their personal information and further more consent to data retention periods as determined by the Fund from time to time.
11. In the event of the processing of personal information of minor children, the parent or guardian of such child undertakes to provide or revoke such consent on behalf of the child.
12. The principal member herewith provides informed consent to the disclosure of any information to an Agent/Intermediary/ Health Care Professional including medical information which gives rise to the completion of the application for the membership and which results as a consequence of an exclusion being applied or the declining of the membership in total or part thereof, this provision enables the Agent/Intermediary/Health Care Professional to provide the member with an explanation as to such underwriting or part or total cancellation.
13. The principal member herewith indemnifies the Fund and its trustees, administrators, intermediaries and employees as well as any other person(s) against any claim arising from the provision and disclosure of the aforementioned information requests.
14. This medical aid fund coverage is issued in Namibia

Section M - Financial Intermediary Review

1. The applicant confirms that he/she was assisted in person/telephonically by the financial intermediary.	2. The applicant confirms that the product was explained and that he/she understands the product and the benefits applicable.
3. The applicant confirms that he/she was asked to declare any medical condition and/or previous treatment received prior to joining date.	4. The applicant confirms that he/she understands that exclusions and/or waiting period may be imposed by the fund inclusive of any pre-existing conditions that were not declared upon joining.

5. The applicant understands that any treatment may be declined in the event that a pre-exiting condition was not declared upon application.

Principal Applicant Signature		Date	D	D	M	M	Y	Y	Y	Y

Section N - Declaration by Financial Intermediary

1	I confirm that I have ascertained and verified the identity of the proposed Applicant, where relevant, as required by FIA Legislation and the Regulations thereto.
2	I confirm that I have, in addition, seen the identity document or passport of the proposed client and herewith declare that the information contained therein coincides with the details provided as part of the application process.

Signed at		on this		day of		2	0	Y	Y

Financial Intermediary Name	
Financial Intermediary Signature	
NAMFISA Reference Number (Where Applicable)	

www.rmanam.com

Renaissance Health Medical Aid Fund

rma.nam

Windhoek
Lüderitz
Oranjemund
Ongwediva
Rosh Pinah
Swakopmund
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