MEMBERSHIP DEPENDANT TERMINATION FORM

Tel: +264 83 2999 000
Email a copy of the completed form to: rma@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 — Your Health Comes First

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																			
Title		Initials		Full Names															
Surname																			
Physical Address																			
Postal Address														Postal code					
Telephone Number	(H) Code													(W) Code					
Cellphone Number														Fax Number					
I.D / Passport Number														Passport Expiry Date					
E-mail Address																			
Date of Birth	D	D	M	M	Y	Y	Y	Y	Age										
Marital Status	Single		Married		Divorced		Widowed		Cohabitation										
Member Signature			Date	D	D	M	M	Y	Y	Y	Y								

Section B - 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						
Contribution Payments via Debit Order Date	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 C - Termination of Dependant

Dep Code	Full Names	Surname	Termination Date (One calendar month notice in advance is required)	KINDLY PROVIDE REASON FOR TERMINATION (COMPULSORY)
			D D M M Y Y Y Y	
			D D M M Y Y Y Y	
			D D M M Y Y Y Y	

Administered by PROSPERITY HEALTH

MEMBERSHIP DEPENDANT TERMINATION FORM

Tel: +264 83 2999 000
Email a copy of the completed form to: rma@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 — Your Health Comes First

Section D - 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																	