EMPLOYER GROUP / CLIENT DETAIL UPDATE FORM

Tel: +264 83 2999 000
E-mail copy of completed form to : rhmafmember@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

Office Use Only

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

CB Number	

Section A - Company Details *(A copy of the Company registration form and/or founding documents must be attached to this application)*

Registered Name			
Trading Name		Registered Number	
Type of Industry		Financial year-end (month)	
Physical Address			
Postal Address			

Company Contact Person

Kindly provide the details of the two most appropriate contact person in your organisation who are directly involved with the company accounts.

HR Manager / Financial Manager				Administrative contact			
Title		Initials		Title		Initials	
First Name				First Name			
Surname				Surname			
Position				Position			
Telephone Number				Telephone Number			
Cellphone Number				Cellphone Number			
Fax Number				Fax Number			
E-mail Address				E-mail Address			

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Section F - Employer's Agreement

I, the undersigned (full names)	

herewith confirms that I am duly authorised by the Employer Group to complete the form on behalf of the Employer Group and that all the information contained herein is, to the best of my knowledge true, correct and complete at the date of signature hereto.

We acknowledge the fact that contributions must be in advance and therefore we agree to ensure that contributions will be paid to the Fund not later than the 7th day of the month to which the contributions pertain.

We agree to submit all amendments before the 7th day of each calendar month as invoices are sent to the Employer 5 (five) working days after the printing of the invoices. Invoices are printed on the 10th day of each month or the consecutive working day.

Option changes are not allowed during the course of a financial period. Should a member resign from the Fund, new application for membership will take place the next financial year/period.

We agree to give one calendar month notice when any member of our group wants to terminate his/her membership of the Fund and agree to take the responsibility upon ourselves if the Fund is not notified on time.

Signed		Date	D	D	M	M	Y	Y	Y	Y
On behalf of											
Signed (Witness)		Date	D	D	M	M	Y	Y	Y	Y
Company Stamp											

Section G - Group Debit Order Authority

Banking Details (Kindly provide confirmation from the bank not older than 3 months.)

Debit Order Date	1st of each month		26th of each month								
Bank Name											
Account Holder's Name											
Account Type	Current		Savings								
Account Number											
Branch Name		Bank Branch Code									
Authorized Signatory Signature		Date	D	D	M	M	Y	Y	Y	Y

For office use only

Processed by											
Signature		Date	D	D	M	M	Y	Y	Y	Y