EMPLOYER GROUP/CLIENT APPLICATION FOR GROUP MEMBERSHIP

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		Joining date of the company	D D M M Y Y Y Y
Trading Name		Registered Number	
Holding Company Name			
Type of Industry		Financial year-end (month)	
Description of the company's main activities			
Specify company/division to which you prefer the monthly billing to be addressed?			

Type of Enterprise *(Kindly mark with an X)*

Public Listed Company		Public Non-listed Company		Private Company		Close Corporation	
Government Institution		Parastatal Organisation		Other (specify)			
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 B - Billing Statement Details

Do you require your employee's numbers to appear on the billing statement?	Yes		No	
How would you prefer your billing to be sorted?	By employee name		By employee number	
How would you prefer to receive your company correspondence?	To be collected		Via email	
How would you prefer your employees to receive their correspondence?	To be collected		Via post	
How will remittance be provided?	Via email		Via hard copy	

Section C - Payment Method

How will monthly contribution payment be made?	Electronic Fund Transfer		Debit Order	

Note:
- The Debit Order Authority section must be completed, should you prefer deductions to be made via debit order.
- Should you prefer to make contribution payments via Electronic Fund Transfer, kindly e-mail or fax through the proof of payment, along with a breakdown of how contributions should be allocated. Also confirm with our office that the proof of payment was received.
- Payments should be done in advance on or before the 7th of each month.
- Failure in making payments will result in suspension of the members and their beneficiaries benefits.
- Termination of membership need to be done one month in advance.

Section D - Option Change Selection *(Effective annually on 1 January)*

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

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										

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Section E - 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

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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