



# APPLICATION FORM FOR EX-GRATIA ASSISTANCE

Please note that an uncompleted form may be to your disadvantage since it may lead the application to being rejected due to the failure to provide the required information.

(\*Amount less than N\$ 1,000-00 will not be considered.  
(No application form is required to be completed.)

\*Kindly note that Ex-gratia assistance is subject to discretion within a set of criteria and merit.

# APPLICATION FOR EX-GRATIA ASSISTANCE

Tel: +264 83 2999 121

Send e-mail to: [exgratia@prosperitynam.com](mailto:exgratia@prosperitynam.com)

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



## Section A - Personal Details

Surname				Member Number								
First Name				Product Option								
ID Number				Date of Birth	D	D	M	M	Y	Y	Y	Y
Title		Sex	M	F	Number of Dependants							
Employee Number				Spouse Name								
Postal Address												
Physical Address												
City				Country								
Name of Employer												
Occupation												
E-mail Address												
Telephone Number	Home				Work							

## Section B - Financial Standing of Applicant *(Provide proof of income/payslip)*

What is your monthly income?	Principal Member	Spouse
Salary		
Pension		
Dividends		
Interest on Investments		
Other (specify)		
<b>TOTAL MONTHLY INCOME</b>		
Are you an employee or a pensioner?		
Proof of income		

## In the event of approval claims to be paid to *(Kindly tick appropriate box)*

Healthcare Professional	<input type="checkbox"/>	Principal Member	<input type="checkbox"/>
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## Section C - Details of Medical Claim / Medical Condition (To be completed by a Medical Specialist)

State the type of medical claim i.e. GP/Specialist name including the total amount.


State the nature of assistance required i.e. benefits exceeded, exclusion etc. including the name of the dependant on whom the application is applicable.


Documents required from GP/Specialist

GP/Specialist motivation letter		Outstanding claims/s	
Specialist Signature (Healthcare Professional)			Stamp

## Section D - Declaration

I herewith declare that I understand that I at all times stay personally responsible for the cost and accounts outstanding for which I am applying assistance for and that I have made an arrangement with the respective Healthcare Professional for a possible delayed payment and/or that I am paying off the account on a monthly basis.

I hereby declare that the answers given and information supplied are true and correct and agree that any false statement in this application shall render the application null and void, in which event all monies paid on my behalf will immediately be repayable to the Fund.

Signature of Principal Member		Date	D	D	M	M	Y	Y	Y	Y
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## Section E - Checklist

Detailed Claims relevant to ex-gratia request		Claims statement from portal applicable to ex-gratia request	
Quotations submitted by member relevant to ex-gratia request		Membership Certificate (to proof membership status and product)	
Print of applicable benefit values on portal.		Proof of income submitted by member	
GP / Specialist motivation letters		MHC Motivation / Recommendation	
Copy of ID / Passport			

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**RMA**  
Renaissance Health  
Medical Aid Fund

## Section F - For Office Use Only

Name of Consultant								Date Received	D	D	M	M	Y	Y	Y	Y	
Incident Number								Name of Assessor									
Date E-Mail sent to Member	D	D	M	M	Y	Y	Y	Y	Ex-Gratia Meeting Date	D	D	M	M	Y	Y	Y	Y
Date Processed	D	D	M	M	Y	Y	Y	Y									
E-Mail Address used																	
Ex-Gratia Outcome																	