MEMBER COMPLAINT FORM

Tel: +264 83 2999 000

E-mail a copy of the completed form to: rmamember@prosperitynam.com

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

Your Health Comes First

RMA Renaissance Health Medical Aid Fund

Complainant Information *(Kindly tick appropriate box)*

Member		Beneficiary	

Name & Surname	
Member Number	
Physical Address	
Identification Number	
Contact Information (Phone, Email)	

Nature of Complaint *(Kindly tick appropriate box)*

Service Quality		Premiums		Coverage and Benefits		Healthcare Provider Claim		Other*	
Other (Specify)*									

Impact of the Complaint *(Kindly tick appropriate box)*

Financial		Emotional		Health	
Other (Specify)					

Anticipated Results

Details of the Complaint *(Kindly indicate the incident dates, full names of parties involved and attach relevant supporting documents.)*

Date of Incident/s	
Person/s Involved	

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Declaration and Consent

I, the undersigned declare the information provided in this complaint form is true and correct. I also consent to the sharing of this information and my identity with relevant third parties involved in the investigation process.

Signature		Date	D	D	M	M	Y	Y	Y	Y

Insurer Notes:
