Nammed MEDICAL AID FUND

This document Is legally binding. Ensure ALL details are complete and correct

APPLICATION FOR MEMBERSHIP
NEW MEMBERS ONLY

NAMMED MEDICAL AID FUND • Telephone: (061) 374 600 • Fax: 061 374 650 • www.nammed.info

How did you become aware of Nammed Medical Aid Fund

- ☐ Radio
- ☐ Newspaper
- ☐ Word of mouth (colleague, acquaintance, friend)
- ☐ Group member
- ☐ Introducer/Employee

Please attach the following to the application:

- Id or passport or birth certificate of principal member & dependant (s)
- Proof of full time study at a registered institution for child dependants between 21 – 25 years of age
- Medical certificate of a mentally/physically disabled dependant over the age of 21

PLEASE COMPLETE ALL THE APPLICABLE SECTIONS IN FULL

A. BENEFIT OPTION - Please tick the applicable box.

COMPREHENSIVE ☐ STANDARD ☐ ESSENTIAL ☐ TRAUMA ☐ ACTIVE ☐ CORE* ☐ BASIC* ☐

B. REQUIRED MEMBERSHIP DATE | | | / | | | / | 2 | 0 | | | **SALARY*** (CORE / BASIC) N$ | | | | | | |

C. APPLICANT'S PARTICULARS:

1. PERSONAL DETAILS

TItle: Prof/Dr/Mr/Mrs/Miss | | | | |

Surname | | | | | | | | | | | | | | | | | | | | | | | | |

First names | | | | | | | | | | | | | | | | | | | | | | | | |

Initials | | | | | Sex M F Date of Birth | | | / | | | / | | | | |

Postal Address | | Physical Address: | |

Marital status | | Language Eng Afr Tel. W ( ) H ( )

ID No. / Passport | | | | | | | | | | | | Cell | |

Employer company | | Fax. W ( ) H ( )

E-mail | |

2. CURRENT/PREVIOUS MEDICAL AID FUND:

Are/were you or any of your nominated dependants members of a registered Medical Aid Fund uninterruptedly for the past 2 years? Yes No

If "yes" please attach a membership certificate (not a membership card) from your current or previous Medical Aid Fund.

NAME OF CURRENT MEDICAL AID FUND: | |

PERIOD OF MEMBERSHIP: From D D M M Y Y Y Y To: D D M M Y Y Y Y

NAME OF PREVIOUS MEDICAL AID FUND: | |

PERIOD OF MEMBERSHIP: From D D M M Y Y Y Y To: D D M M Y Y Y Y

PARAMOUNT HEALTHCARE MEDICAL AID ADMINISTRATORS CC

D. PARTICULARS OF DEPENDANTS

DEPENDANTS Husband/Wife and children under 21 years, unmarried and not in full-time employment, if dependant full-time student at educational institution, up to 25 years of age.

DEPENDANTS	FULL NAMES	RELATIONSHIP TO APPLICANT

SPOUSE

FULL NAMES | RELATIONSHIP TO APPLICANT

ID No. / Passport | Sex M F | Date of Birth / /

ADULT DEPENDANT

FULL NAMES | RELATIONSHIP TO APPLICANT

ID No. / Passport | Sex M F | Date of Birth / /

ADULT DEPENDANT

FULL NAMES | RELATIONSHIP TO APPLICANT

ID No. / Passport | Sex M F | Date of Birth / /

1ST CHILD

FULL NAMES | RELATIONSHIP TO APPLICANT

ID No. / Passport | Sex M F | Date of Birth / /

2ND CHILD

FULL NAMES | RELATIONSHIP TO APPLICANT

ID No. / Passport | Sex M F | Date of Birth / /

3RD CHILD

FULL NAMES | RELATIONSHIP TO APPLICANT

ID No. / Passport | Sex M F | Date of Birth / /

4TH CHILD

FULL NAMES | RELATIONSHIP TO APPLICANT

ID No. / Passport | Sex M F | Date of Birth / /

5TH CHILD

FULL NAMES | RELATIONSHIP TO APPLICANT

ID No. / Passport | Sex M F | Date of Birth / /

6TH CHILD

FULL NAMES | RELATIONSHIP TO APPLICANT

ID No. / Passport | Sex M F | Date of Birth / /

E. STATE OF HEALTH: Please place an X in the applicable block. *Applicable to Principal Member and Dependants*

1. Are you now pregnant? Yes No If so, how many months? ____ Name of Person ____

2. Have you or any of your dependants ever suffered from any of the following? If "Yes", provide full particulars in 8 below.

	STATE	
2.1. Any disorder of the heart, e.g. rheumatic fever, heart murmur, coronary artery disease, chest pain, shortness of breath or palpitations?	Yes	No
2.2 High blood pressure or disease of the blood vessels or circulatory disorder?	Yes	No
2.3 Any respiratory or lung trouble, e.g. asthma, bronchitis, persistent cough, tuberculosis?	Yes	No
2.4 Any disorder of the digestive system, gall bladder or liver, e.g. actual or suspected gastric or duodenal ulcer, recurrent indigestion or hiatus hernia?	Yes	No
2.5 Disease or disorder of kidneys, bladder or reproductive organs, e.g. albumin in urine, kidney stones, prostatitis, pancreatitis or venereal disease?	Yes	No
2.6 Any nervous or mental complaint, e.g. epilepsy, black-outs, paralysis, anxiety state or depression?	Yes	No
2.7 Ear, eye, nose or throat disorder, e.g. ear discharge, defective vision, recurrent tonsillitis?	Yes	No

2.8 Disorder or disease of muscles, bones, joints, limbs, spine, e.g. rheumatism, arthritis, gout, slipped disc or other back trouble?	Yes	No
2.9 Diabetes, sugar in urine, thyroid or other glandular or blood disorder?	Yes	No
2.10 Cancer, growth or tumour of any kind?	Yes	No
2.11 Any tropical disease, e.g. bilharzia?	Yes	No
2.12 Any other illness, disorder, disability or accident which required medical, radiological, surgical or pathological investigations during the past 3 years?	Yes	No
2.13 Received or expect to receive any medical advice, counselling, treatment or blood test in connection with AIDS or an AIDS-related condition?	Yes	No
3. Do you or any of your dependants have any physical (including dental) abnormality, deformity, handicap or defect, whether congenital or as a result of an accident, disease or some other cause? If "Yes", please provide full particulars in 8 below.	Yes	No
4. Do you or any of your dependants suffer from any ailment or disease at present? If "Yes", please provide full particulars in 8 below.	Yes	No
5. Are there, in respect of you or any of your dependants, any other circumstances not mentioned elsewhere in this declaration/questionnaire, relating to past or present diseases, accidents, operations or other conditions including pregnancy for which advice has been sought or treatment has been received or recommended during the past 5 years? If "Yes", please provide full particulars in 8 below.	Yes	No
6. Are you or your dependants expecting to undergo any procedure, operation, confinement or receive any major dental treatment during the next 12 months?	Yes	No

7. Length and Weight of PM _____cm _____kg Length & Weight of AD 1 _____cm _____kg

Length & Weight of AD 2 _____cm _____kg Length & Weight of AD 3 _____ cm _____kg

8. PARTICULARS REQUIRED IF YOU HAVE ANSWERED "YES" TO ANY OF THE ABOVEMENTIONED QUESTIONS (E1-6). A MEDICAL/DOCTOR'S NOTE MAY BE REQUESTED TO EVALUATE THE CONDITION/ILLNESS/TREATMENT.

Question No.	Name of Patient	Please state the illness or condition, date and duration of illness or condition	The date and nature of treatment received; medical or surgical result of the treatment should be stated.	Please include the name of the doctor, hospital or institution and address.	If future treatment is recommended, please specify likely date and duration of treatment

F. CERTIFICATE BY EMPLOYERS (Applicable only to EMPLOYERS registering their **groups as compulsory groups)**

I/We, _____ (name of employer) of (address) _____

_____ Tel. No. ( ) _____ and code Fax _____

herewith declare that the applicant is a member of my/our staff and I/we undertake to guarantee and pay all monies owed by the employee in respect of MEMBERS' SUBSCRIPTIONS and CLAIMS, to NAMMED MEDICAL AID FUND. I also state that the employee's present gross salary

is N$ _____ per month, and that I/we shall notify you immediately of any change in this salary.

The employee joined my/our staff on _____ 20 _____ Employee's present age: _____

Employee Payroll number: | | | | | | | | | | | | | | | | | | | | | | |

This group will be known as _____

Signed at _____ this day _____ of _____ 20 _____

Signature of employer / his assignee _____ Witness _____

PARAMOUNT
HEALTHCARE MEDICAL AID ADMINISTRATORS CC

G. STATEMENT BY THE APPLICANT, TERMS & CONDITIONS

This agreement shall take effect wherever the NAMMED head office is situated.

1. I, the undersigned applicant, hereby apply for membership of NAMMED. Should my application be approved, I regard myself, through my signature below, to be committed to the existing rules of the Fund as well as all additions or amendments which may be accepted from time to time. I hereby state that all answers given in this application **are in every respect true and complete and represent the full particulars required, and if any illness of which I might be aware at the time of signing this document be kept secret, or if incomplete or false information as far as such illness is concerned be submitted and comes to NAMMED's attention, I shall disclaim any benefits provided by the Fund in that respect.** Should a dispute arise on the question whether a state of disease existed before the date of application, ***I shall bear the onus of proving that it did not.***
2. I agree that this statement and any supplementary statement(s) shall constitute the basis of my application for membership of NAMMED and I agree that if any answers should prove to be false, incomplete or possibly misleading, NAMMED, apart from any other rights, shall be entitled to (i) terminate my membership and (ii) claim repayment of all benefits which I had received in respect of the state of disease or the situation on account of which my membership had been terminated; or as an alternative to (ii), (iii) retain any amount paid in advanced as liquidated indemnification, whether my membership be terminated or not.
3. I also herewith give my consent that:
   - 3.1) In the event that I cancel my membership or my membership is cancelled for any other reason, the Fund shall have the right to deduct any amount indebted by me to the Fund (outstanding contributions or amounts spent in excess of the allowable day-to-day benefit limit(s) from the amount indicated as a credit in my "Self-insurance Pool credit account" (if applicable);
   - 3.2) The balance of the SIP Credit Account (if any), after deduction of the amount owed to the Fund, to be paid out (to the bank account details on record) as part of the first claim run following the month of resignation. Should there be any requests for a refund after the given period; the onus is on the person to prove that they were a member of the Fund.
4. I, the undersigned hold myself responsible for payment of the monthly contributions to the Fund as per the registered Rules of the Fund;
5. I am aware that contributions are payable monthly in advance before or on the 7th of each month following. Should my contribution payments be in arrears with 30 days, benefits shall be suspended. Should my contributions be 60 days in arrear - benefits will be cancelled and the Fund reserves the right to institute legal action to collect arrear contributions and, if I apply for reinstatement of benefits, the Fund reserve the right to decline such reinstatement;
6. I hereby consent that, in the event of the Fund having to take legal action via its legal collections department or designated institution, an **Administrative Fee** will be added onto the outstanding contribution statement amount prior to the handing-over process;
7. I further consent that, at the option of the Fund, any claim against a member may be brought in any Magistrate's Court having jurisdiction notwithstanding that the amount of the claim exceed the jurisdiction of the Magistrate's Court.
8. I the undesigned understand that I have to give one month's written notice to cancel my medical aid.

Signed at _____ this _____ day of _____ 20 _____

Signature of the applicant _____ Witness _____

I. BANK ACCOUNT DETAILS FOR CLAIM REFUNDS

(REQUIRED TO REFUND MEMBERS FOR AMOUNTS DIRECTLY PAID BY THE MEMBER)

Name of account holder:

Account No: Branch Code:

Name of Bank:

Type of Account: ☐ Savings ☐ Cheque ☐ Transmission

H. PLEASE INDICATE METHOD OF PAYMENT (for monthly contribution):

☐ EFT / Electronic bank transfer ☐ Cheque ☐ Cash ☐ Debit order

J. BANK ACCOUNT DETAILS FOR CONTRIBUTION PAYMENTS VIA DEBIT ORDER

(REQUIRED FOR DEBIT ORDER AUTHORISATION, DIRECTLY FROM YOUR BANK ACCOUNT)

Name of account holder:

Account No: Branch Code:

Name of Bank:

Type of Account: ☐ Savings ☐ Cheque ☐ Transmission

I,We request that the NAMMED MEDICAL AID FUND make the necessary arrangements with my/our bank according to the debit order system to collect the subscription fees according to the rules of NAMMED Medical Aid Fund (as amended from time to time), arrear contribution/amounts (where applicable) and debt repayments (where requested) in connection with my application against my/our account (wherever such account is kept).

I,We agree to pay any expenses concerning this debit order, and understand that all drawings, hereby authorised, will be printed on my/our bank statement or an accompanying slip. This authorisation can be cancelled by me/us **by giving 30 days notice** which is sent by prepaid registered post, but I/we understand that I/we are not entitled to the repayment of any amount which was drawn while the authorisation was effective, if such amounts were legally due to NAMMED Medical Aid Fund. The receipt of this instruction by you will act as acceptance by my/our Bank.

Signed at _____ this _____ day of _____ 20 _____

Signature of account holder: _____ Witness _____