EMPLOYMENT TRANSFER FORM

Tel: +264 83 2999 736
E-mail copy of completed form to: rhmafmember@prosperitynam.com

Renaissance Health
Medical Aid Fund

Section A - Employment Details *(Please tick appropriate box.)*

Private		Company		Membership Number													
Previous Company Name																	
New Company Name																	
New Company Address																	
New CB Number									Effective Date	D	D	M	M	Y	Y	Y	Y
Telephone Number									Postal Address								
Employee Number									Employment Date	D	D	M	M	Y	Y	Y	Y
Designation of Employee																	
Salary	Applicable to Income based products																

Section B - Member Details

Title		Initials		Full Names													
Surname																	
Physical Address																	
Postal Address													Postal code				
Telephone Number	Home								Work Number								
Cellphone Number									Fax Number								
E-mail Address																	
Date of Birth	D	D	M	M	Y	Y	Y	Y	Age		I.D. / Passport no.						
Copy of I.D./Passport book to be attached to the application form - legally required																	
Marital Status		Single		Married		Divorced		Widowed		Common Law							

Section C - Bank Details *(For Debit Order Premiums or EFT Claim Refunds) (Attach proof of bank account details)*

IMPORTANT NOTICE: It is compulsory to supply Prosperity Health with this information. (In the event that refunds should be deposited into a different bank account, attach details as well.)						Effective Date	D	D	M	M	Y	Y	Y	Y
Claims Refund														
Contribution Payments via Debit Order Date			1st of every month				26th of every month							
Name of Account Holder														
Bank Name						Bank Branch Name								
Account Number						Bank Branch Code								
Type of Account	Cheque / Current		Savings			Signature of Account Holder								

prosperity-2020

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Section D - Product Option Selection

Main Product

Elite Care		Prestige Care		Status Care	
Caliber Care		Esteem Care *(Individual Contribution - Age based)*		*Esteem Care *(Group Contribution - Age/Income based)*	
Evolve Care *(Individual Contribution - Age based)*		Evolve Care *(Group Contribution - Age/Income based)*		*Premiere Care (For groups of 10+ members)	

** Only applicable to Group Schemes. Salary advice should be attached. A maximum salary scale applies.*

Benefit Builders *(A Benefit Builder automatically terminates on the 31st December of the applicable benefit year.)*

Family Benefit		Monthly Contribution	Effective Date						Family Benefit		Monthly Contribution	Effective Date						
N$ 3,000		N$ 225	D	D	M	M	Y	Y	N$ 15,000		N$ 1,125	D	D	M	M	Y	Y	
N$ 5,000		N$ 375	D	D	M	M	Y	Y	N$ 17,000		N$ 1,275	D	D	M	M	Y	Y	
N$ 7,000		N$ 525	D	D	M	M	Y	Y	N$ 20,000		N$ 1,500	D	D	M	M	Y	Y	
N$ 10,000		N$ 750	D	D	M	M	Y	Y	N$ 22,000		N$ 1,650	D	D	M	M	Y	Y	
N$ 12,000		N$ 900	D	D	M	M	Y	Y	N$ 25,000		N$ 1,875	D	D	M	M	Y	Y	

Inclusive Insurance Products:
Please take note that the option selected include the following insurance benefits of which the **risk** is fully underwritten by a registered insurer, as required by the Medical Aid and Insurance Acts: Emergency evacuation cover, memorial transportation cover, premium protection cover and travel assistance.

Optional Insurance Products:
The following insurance benefits are not included in the options selected and is optional. The risk is fully underwritten by a registered insurer, as required by the Medical Aid and Insurance Acts.

Please mark with an (X) if cover is required.		Effective Date							Termination Date						
Funeral Standard Policy		D	D	M	M	Y	Y		D	D	M	M	Y	Y	
Funeral Select Policy		D	D	M	M	Y	Y		D	D	M	M	Y	Y	
Complimed Plus		D	D	M	M	Y	Y		D	D	M	M	Y	Y	
Combo (Funeral Cover / Complimed Plus / Hospicash)		D	D	M	M	Y	Y		D	D	M	M	Y	Y	

Identification and Verification: Financial Intelligence Act, 13 of 2012 (FIA)

I hereby confirm that the information provided to me by the Policyholder, has been verified against the documentation provided and that the identity of the Policyholder has been established and verified as required in terms of Section 21 of the FIA.

Broker / Agent Name		Date	D D M M Y Y Y Y
Signature of Broker / Agent			

Section E - Funeral Beneficiary *(The beneficiary who will be paid the benefit in the event of a death.)*

Name	Surname	I.D. / Passport Number	Relationship

Section F - Declaration

I declare that to the best of my knowledge the information given above is true and correct

Member's Signature	
Date	D D M M Y Y Y Y

Section G - Documentation *The following documentation should accompany the application form as per the Financial Intelligence Act 2012 (FIA) where applicable:*

Namibian Citizen	Yes		No		
ID / Passport of main member			Proof of banking details (Please attach confirmation from the bank)		
Payslip for options Primary Care, Vital Care and Econo Care					