OPTION TRANSFER / EFT / DEBIT ORDER FORM

PRIVATE HOSPITAL GAP PLAN FOR
PSEMAS HIGHER OPTION &
PSEMAS STANDARD OPTION

Tel: +264 83 2999 000 / +264 83 2999 543
E-mail queries: clientservices@prosperitynam.com

Section A - Policyholder Details *(We could request proof of this source.)*

*Source of Funds	Salary		Private Business		Parental Support		If other, please specify		
Policy Number					I.D./Passport Number				
Full Names					Surname				
Physical Address									
Postal Address							Postal code		
Telephone Number	H	Code					Cellphone Number		
E-mail Address									

Section B - Policy Option Selection *(Attach proof of PSEMAS membership)*

Please indicate with an (X) in the appropriate block which policy you wish to select or if you wish to remain on the same policy.
Please attach proof of your bank account details and a copy of your PSEMAS membership card / proof of membership to this form. If you are a member on the PSEMAS Higher Option you need to provide proof to be able to change to the Complimed HIGHER Option Policy.

Complimed GAP STANDARD Policy *(This plan is for PSEMAS Standard Option policyholder ONLY)*		**Complimed GAP HIGHER Policy** *(This plan is for PSEMAS Higher Option policyholder ONLY)*	

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

Name	Surname	I.D. / Passport Number	Relationship

Section D - Premium and Refunds *(For Debit Order Premiums, Payroll deduction or EFT Claim Refunds) (Attach proof of bank account details)*

IMPORTANT NOTICE: It is compulsory to supply Prosperity Life 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

Premium Payments	Debit Order (select debit order date below)		Payroll Deduction		Claims Refund	
Debit Order Date	1st of every month		20th of every month		25th of every month	
Employee Number						
Name of Account Holder						
Bank Name			Bank Branch Name			
Account Number			Bank Branch Code			
Type of Account	Cheque		Transmission		Savings	

I hereby authorize Prosperity Lifecare Insurance Limited to initiate premium deductions from my salary in accordance with the terms and conditions of this policy. I understand and agree that I am responsible for satisfying the amount as agreed. I understand and agree that any amount that is due and owing at the time of my termination, regardless of whether my termination was voluntary or not, will be deducted from my last salary.

Signature of Account Holder		Date	D	D	M	M	Y	Y	Y	Y

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Section E - Declaration by Policyholder

I declare to the best of my knowledge and belief that the information given above is true and correct. I understand and agree that any willful misrepresentation in this application form will invalidate any benefit under this Policy. I declare that I have read and understood the terms and conditions attached to this Policy, and understand their meaning and effect, and undertake to abide and to be bound by the terms and conditions of the Policy. Prosperity Lifecare Insurance Limited shall not be liable for any amount until it has accepted this application and this Policy is in force.

Signed at		on this		day of		2	0	Y	Y
Policyholder Name									
Policyholder Signature									

Section F - Documentation

Namibian Citizen	Yes		No		

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

ID / Passport of Policyholder		Proof of banking details (e.g. cancelled cheque, bank statement, etc)	
Copy of PSEMAS membership card / proof of membership			

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 G - Addendum

Prosperity Lifecare Insurance Ltd hereby extends its sincerest gratitude to you for considering us as your potential Insurer of choice. Kindly note the below details prior to completing the application form. Please 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 please feel free to contact the Client Services Department at Tel: +264 83 2999 736.

1. It is very important that the application form be completed in full in order to ensure that all due considered information is provided.
2. We urge you to note the importance of the medical history section in respect of which we encourage prospective policyholder to be most forthcoming as any omission or misrepresentation of fact may have serious consequences in respect of this policy.
3. Where Prosperity Lifecare Insurance Ltd elects to effect restrictions or exclusions on the principal policyholder or any of the policyholder's beneficiaries, this will be communicated in writing to yourself for approval of the restrictions/exclusions, once signed off by yourself, the registration process may then be completed.
4. Where a policyholder applies for a policy during the course of a benefit year, it is important to take note that policy benefits will be pro-rated.
5. It may be required that you be requested to provide additional information or undergo medical testing in order to ensure the processing of your application, if this is required you will be duly informed.

Section H - Broker / Agent Review

The Policyholder hereby acknowledges his/her understanding of the below

1. He/She was in fact seen by the Broker / Agent in person.	2. He/She was given a thorough understanding of the policy and the insured cover.
3. He/She was asked to declare any previous treatment received in the last 24 months prior to joining date.	4. He/She understands that exclusions and waiting period may be imposed by the Insurer even if found to be pre-existing conditions that were not declared upon joining.
5. He/She understand that treatment may be declined for pre-exiting conditions for which treatment was received within 24 months prior to joining where such conditions were not declared upon application.	

Policyholder Signature		