

EMPLOYER GROUP/CONSTITUENT BODY APPLICATION FORM



Tel: +264 83 2999 000

E-mail queries: clientservices@prosperitynam.com

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

CB Number							
Section A - Financial Intermediary Details							
Registered Name							
Contact Person						TPM Number	
Cellphone Number							
Telephone Number					Fax Number		
E-mail Address							
Section B - Company Details							
Registered Name					Registration Number		
Trading Name							
Holding Company Name							
Type of Industry					Financial year-end (month)		
Description of the company's main activities							
Specify company/division to which you prefer the monthly billing to be addressed?							
Type of Enterprise (Please mark with an X)							
Public Listed Company	<input type="checkbox"/>	Public Non-listed Company	<input type="checkbox"/>	Private Company	<input type="checkbox"/>	Close Corporation	<input type="checkbox"/>
Government Institution	<input type="checkbox"/>	Parastatal Organization	<input type="checkbox"/>	Other (specify)			
Address (Please complete both sections. This must be the address where you require correspondence and billing statement to be posted.)							
Physical Address							
Postal Address							
Contacts (Please supply the details of the two most appropriate people in your organisation who are directly involved with the company accounts.)							
HR Manager / Financial Manager				Administrative contact			
Title		Initials		Title		Initials	
First Name				First Name			
Surname				Surname			
Telephone no.				Telephone no.			
Cellphone no.				Cellphone no.			
Fax no.				Fax no.			
E-mail Address				E-mail Address			

prosperity-2022

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Section C - Billing Statement Details

Joining date of the company		D	D	M	M	Y	Y	Y	Y
Do you require your employee's numbers to appear on the billing statement?	Yes					No			
How would you prefer your billing to be sorted?	By employee name					By employee number			
How would you prefer to receive your company correspondence?	To be collected					Via email			
How would you prefer your employees to receive their correspondence?	To be collected					Via post			
How will remittance be provided?	Via email					Via hard copy			

Section D - Payment Method

How will monthly contribution payment be made?	Electronic Fund Transfer			Debit Order	
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Note:

- The 'Debit Order Authority' (Section H) must be completed, should you prefer deductions to be made via debit order.
- Should you prefer to make contribution payments via Electronic Fund Transfer, please e-mail or fax through the proof of payment, along with a breakdown of how contributions should be allocated. Also confirm with our office that the proof of payment was received.
- Payments should be done in advance on or before the 7th of each month.
- Failure in payments will result in suspension of the members and their beneficiaries.
- Terminations need to be done one month in advance.

Section E - Employer's Agreement

I, the undersigned (full names)										
do hereby declare that I am instructed by the applicant company to make this application and that all the information contained herein is, to the best of my knowledge and belief, true, correct and complete at the date of signature hereto.										
We acknowledge the fact that contributions must be in advance and therefore we agree to ensure that contributions will be paid to the Prosperity Lifecare Insurance not later than the 7th day of the month to which the premiums pertain.										
We agree to submit all amendments before the 7th day of each calendar month as invoices are sent to the Employer 5 (five) working days after the printing of the invoices. Invoices are printed on the 10th day of each month or the consecutive working day.										
Option changes are not allowed during the course of a financial period. Should a Policyholder resign from the Prosperity Lifecare Insurance, new application will take place the next financial year/period.										
We agree to give one calendar month notice when any Policyholder of our group wants to terminate his/her membership of the Prosperity Lifecare Insurance and agree to take the responsibility upon ourselves if the Prosperity Lifecare Insurance is not notified on time.										
We further agree that this contract is valid for a minimum period of 12 (twelve) months and thereafter may only be cancelled by giving 90 days written notice.										
Signed		Date	D	D	M	M	Y	Y	Y	Y
On behalf of										
Signed (Witness)		Date	D	D	M	M	Y	Y	Y	Y
Company Stamp										

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Section F - Policy Option Selection (Medical Insurance Policy)

Please indicate with an (X) in the appropriate block which cover you wish to select.

	Optional MEDBUX - Choose level of cover									
	Level 1 N\$ 200		Level 2 N\$ 300		Level 3 N\$ 400		Level 4 N\$ 500		Level 5 N\$ 700	
	Level 6 N\$ 1,000		Level 7 N\$ 1,500		Level 8 N\$ 2,000		Level 9 N\$ 2,500		Level 10 N\$ 3,000	
	Level 11 N\$ 4,000									

Section G - Optional Add-On Policies

Please mark with an (X) if cover is required.	Effective Date						Please mark with an (X) if cover is required.	Effective Date					
*Funeral Standard Policy	D	D	M	M	Y	Y	3-in-1 Combo (Funeral Cover / Complimed Plus / Hospicash)	D	D	M	M	Y	Y
*Funeral Select Policy	D	D	M	M	Y	Y	RescueMe	D	D	M	M	Y	Y
Complimed Plus	D	D	M	M	Y	Y							

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

Name	Surname	I.D. / Passport Number	Relationship

Section I - Bank Details (For Debit Order Premiums 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
Claims Refund																					
Premium Payments via Debit Order Date	1st of every month			20th of every month			25th 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								

Section J - Disclaimer

1	Upon approval of the application, every Policyholder shall, by virtue of his/ her signature on the application form, be deemed to have acknowledged that he/ she and his/ her beneficiaries are bound by all terms and conditions of this policy.
2	Upon approval of the application, every Policyholder shall, by virtue of his/ her signature on the application form, be deemed to have acknowledged that he/ she and his/ her beneficiaries, consent, if so required or deemed necessary, to the use of their medical data for medical purposes/programs such as managed care programs to be used / disclosed to relevant services providers of the Insurer subject to confidentiality and protection of the Policyholder's information.

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Section K - 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 000.

1. It is very important that the application form be completed in full in order to ensure that all duly 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.
6. You hereby guarantee that the information supplied by yourself is complete and accurate and this affirmation is extended to any information which in the reasonable opinion of the Insurer is relevant to the insurance risk and where it transpired that the information provided by yourself is incomplete and inaccurate the Insurer may cancel this policy and premiums paid up to such cancellation shall be deemed forfeited by yourself.
7. The Insured acknowledges that he or she has a right to request and to have directly submitted to themselves upon due request, a copy of any documentation that is submitted by or on behalf of the Policyholder to the Insurer in as far as same applies to the policyholder
8. In due compliance with the Prevention of Organised Crime Act, Act 29 of 2004, the Insured herewith confirms that the fund that will be utilised for the payment of premiums, in terms of this policy, are and shall continue to be derived from a lawful source. The Policyholder additionally hereby avails themselves to provide, upon request any added clarity or documentation as requested by the Insurer to ensure the validity of the source of Funds.
9. The Policyholder herewith consents to the capturing, storage and recording of information as provided electronically on a computer, the Insurers computer system records will constitute the record of this transaction and may be utilised as evidence in a court of law should same be required. The Policyholder additionally consents to the processing and storage of their personal information and special personal information in compliance with and for due usage in regard to the purpose for which it is obtained, inclusive of direct marketing, with due cognisance of international best practice in this regard and requisite legislation.
10. In the case of the processing of special personal information of minor children, the parent or guardian of such child undertakes to provide or revoke such consent on behalf of the child.
11. The Policyholder herewith provides informed consent to and further consents to the disclosure to a Financial Intermediary / Health Care Professional as to medical information which gives rise to the completion of the application for the policy and which results as a consequence of an exclusion being applied or the declining of the policy in total or part thereof, this provision enable the Financial / Intermediary/Health Care Professional to provide the Insured with an explanation as to such underwriting or part or total cancellation.
12. The Insured herewith indemnifies the Insurer and its directors, agents, intermediaries and employees as well as any other person(s) against any claim arising from the provision and disclosure of the aforementioned information requests.
13. This policy is issued in Namibia.

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

Company registration document	Proof of banking details (Please attach confirmation from the bank)
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*Verified Copy

In terms of the Financial Intelligence Act, 2012 (Act 13 of 2012) (FIA) in compliance with Section 22 of FIA all documents should be verified, in respect of which we elect to have a certified copy. Financial Intermediaries and certain employees may verify/ascertain a copy against the original. To verify a copy without the original is in contravention of FIA and constitutes a criminal offence.

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 FIA.

Financial Intermediary Name	Date	D	D	M	M	Y	Y	Y	Y
Signature of Financial Intermediary									

For office use only

Processed by									
Signature	Date	D	D	M	M	Y	Y	Y	Y

Insurer Notes:

Approved by:

1	
2	
3	
4	