

# POLICYHOLDER COMPLAINT FORM

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



## Complainant Information *(Kindly tick appropriate box)*

Policyholder		Beneficiary	
Name & Surname			
Policy 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	

