PROSPERITY LIFE

AMENDMENT FORM

Kindly read Addendum notes before completing this form.

OPTION CHANGE / BENEFICIARY REGISTRATION / BANK DETAIL UPDATE / BENEFICIARY TERMINATION

083 2999 000
www.prosperitylifeafrica.com

Prosperity Lifecare Insurance terms and conditions apply.

Prosperity Life

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BENEFICIARY REGISTRATION OR TERMINATION / OPTION CHANGE / BANK DETAIL CHANGE FORM

PROSPERITY LIFE

Tel: +264 83 2999 000
E-mail queries: life@prosperitynam.com

Kindly do not use tippex in the completion of this form - kindly initial where corrections have been made and complete accordingly.

Policy Number	Processed by/Date	Representative Information (Representative Number)

Insurer Notes:

1	

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Screened		Captured		QC		Scanned	
Date		Date		Date		Date	
Signature		Signature		Signature		Signature	

Section A - Policyholder Details *(Applicant will be the Policyholder)

*Source of Income	Salary		Private Business												
Source of funds, kindly specify															
Title		Initials		Full Names											
Surname															
Previous Names (If any)					Nationality										
Physical Address															
Postal Address					Postal code										
Telephone Number	**(H)** Code				(**W**) Code										
Cellphone Number					Fax Number										
I.D./Passport Number					Passport Expiry Date	D	D	M	M	Y	Y	Y	Y		
E-mail Address															
Date of Birth	D	D	M	M	Y	Y	Y	Y	Age		Weight		Height		
Marital Status	Single		Married		Divorced		Widowed		Cohabitation						

Section B - Employment Details *(Kindly tick appropriate box / Compulsory for Policyholders belonging to an Employer Group)*

Private		Company		CB Number													
Company Name																	
Telephone Number																	
Company Postal Address																	
Employee Number									Employment Date	D	D	M	M	Y	Y	Y	Y
Management Representation									Date	D	D	M	M	Y	Y	Y	Y
Name					Company Stamp												
Designation																	
Authorised Signatory Signature																	

Section C - Beneficiaries to be Covered *(Attach copy of ID/s/full birth certificates)*

Height	Weight	First Name	Surname	Relationship	Gender		Date of Birth					
					F	M	D	D	M	M	Y	Y
					F	M	D	D	M	M	Y	Y
					F	M	D	D	M	M	Y	Y
Proposed Date of Joining	0	1	M	M	Y	Y	Y	Y				

BENEFICIARY REGISTRATION OR TERMINATION / OPTION CHANGE / BANK DETAIL CHANGE FORM

Section D - Termination of Beneficiaries

Dep Code	FULL NAMES	SURNAME	TERMINATION DATE (One calendar month notice in advance is required)	REASON FOR TERMINATION (COMPULSORY)
			D D M M Y Y Y Y	
			D D M M Y Y Y Y	
			D D M M Y Y Y Y	
			D D M M Y Y Y Y	
			D D M M Y Y Y Y	

Section E - Policy Option Selection *(Medical Insurance Policy)*

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

OXYGEN MEDICAL INSURANCE

	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 F - Optional Add-On / Termination of Add on Policies

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

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

Name	Surname	I.D. / Passport Number	Relationship

Section H - Premium and Refunds *(For Debit Order Premiums, Claim Refunds) (Kindly provide proof of bank details not older than 3 months.)*

IMPORTANT NOTICE: It is compulsory to provide 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)		Claims Refund										
Debit Order Date	1st of every month		20th of every month			26th 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 bank 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 bank.

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

BENEFICIARY REGISTRATION OR TERMINATION / OPTION CHANGE / BANK DETAIL CHANGE FORM

Section I - Medical History *(To be completed if adding a new beneficiary or adding a new policy.)*

Supply full details on questions below. Where an answer to a question is "Yes", kindly provide comprehensive details in the space provided below.
Questions pertain to Applicant and **ALL BENEFICIARIES**.

		Non-disclosure of information may result in termination of policyholder insured cover or non-payment of some medical treatment. Have you / your spouse or any one of your beneficiaries ever experienced any of the following? **Kindly mark (x) the relevant box.**	Answer	
			Yes	**No**
1	Cardio Vascular	Chest pain/angina, heart attack, heart failure, heart valve disease, rheumatic fever, high blood pressure, (hypertension), high cholesterol, heart murmurs, circulatory problems/disorders, varicose veins, deep vein thrombosis(DVT), or any other heart or circulatory problems.		
2	Respiratory & Breathing	Asthma, difficulty with breathing, bronchospasm, turbeculosis(TB), coughing up blood, emphysema, pneumonia, cystic fibrosis, chronic bronchitis, shortness of breath, any other breathing problems. Smoking.		
3	Bladder & Kidneys	Blood in urine, kidney failure, polycystic kidneys, kidney or bladder infections, removal of kidney(nephretomy), kidney stones, abnormal kidney or urine tests or any other kidney problems.		
4	Reproductive & Gynae	Endometriosis, infertility, ovaria cysts, hysterectomy, abnormal PAP smear, laser treatment, cervix and breast biopsies, fibro-adenosis of the breast, laparoscopies, hormone replacement therapy, prostate infections or surgery, prostate enlargement or any other reproductive problems.		
5	Digestive System	Duodenal ulcers, gastric ulcers, peptic ulcers, hiatus hernia, colon problems, crohn's disease, ulcerative clitis, gall bladder problems, liver problems or any other digestive problems. Obesity.		
6	Ear, Nose & Throat	Deafness, ear infections, sinus problems, nasal surgery, throat surgery, tonsils.		
7	Dental	Orthodontic treatment, dental surgery, speech impairment, harelip, cleft palate, or any other such surgery.		
8	Eyes	Blindness (partial or full), eye surgery, lens implant, cataracts, glaucoma, renitis pigmentosa, renita detachment, impaired vision, or any other eyesight problems.		
9	Endocrine	Diabetes mellitus or insipidus, underactive thyroid, overactive thyroid, thyroid surgery, crushing's syndrome, addison's disease, pituitary gland, gland problems or any other glandular problems.		
10	Back & Muscles	Neck or back problems or operations, recurrent back pain, osteoporosis, ankylosing spondylitis, rheumatoid arthritis, osteo-arthritis, disease, or any other bone or skeletal disorders.		
11	Neurological	Epilepsy, stroke (CVA), migraine, brain or head injuries, spinal cord injuries, paralysis, multiple scelerosis, mental retardation, narcolepsy, motor neuron disease,parkinson's disease, alzheimer's disease, or any other neurological problems.		
12	Psychological	Depression, anxiety, psychosis, suicide attempts, biopolar disorders, manic depression, "stress", schizophrenia, tourete's syndrome, anorexia nervosa, received advice, counselling or hospitalisation for alcohol or drug abuse, attention deficit disorders, Bulimia or any other psychological conditions.		
13	Tumours & Growths	Benign or malignant growths or lumps or tumours including melanomia, lymph gland cancer, leukaemia, breast cancer or any other tumours, growths and cancers.		
14	Blood	Blood or bleeding disorders e.g. haemophilia, christmas factor deficiency, platelet or any other blood clotting disorders.		
15	Skin	Eczema, acne, dermatovovsitis, psoriasis, scleroderma, or any other skin disorders.		
16	Sexually Transmitted Disease	Advice, treatments or counselling for any of the following: HIV/AIDS, syphilis, gonorrhoea, herpes, genital ulcers, pelvic infectious disease, genital warts, hepatisis B or any other sexually transmitted disease or disorder.		
17	Hospitalisation	Have you, your spouse or any beneficiaries ever been hospitalised? If yes, how frequently.		
18	Treatment & Surgery	Are you, your spouse or any beneficiaries expecting any medical or dental advice, treatment, or are you planning any such treatment within the next three to six months?		

BENEFICIARY REGISTRATION OR TERMINATION / OPTION CHANGE / BANK DETAIL CHANGE FORM

Section I - Medical History *(To be completed if adding a new beneficiary or adding a new policy.)*

Non-disclosure of information may result in termination of policyholder insured cover or non-payment of some medical treatment.
Have you / your spouse or any one of your beneficiaries ever experienced any of the following? **Kindly mark (x) the relevant box.**

			Answer	
			Yes	No
19	Dangerous Pastimes	Are you, your spouse or any beneficiaries participating in any hazardous sport or occupations, e.g. motor or motorbike or motorboat racing, dragster racing, bungee jumping, skydiving, scuba diving or any other hazardous pursuits?		
20	Pregnancy	Are you, your spouse, or any beneficiaries currently pregnant? Should the answer be "yes", when is the expected date of delivery (yyy/mm/dd)		
21	Other	Are there any other factors related to you or your beneficiaries' health that is not disclosed above?		
22	Planned Treatment	During the last 12 months, have you, your spouse or any beneficiaries had any treatment or are you planning any treatment within the next six months?		

If you answered "yes" to any of the above questions, kindly provide the date of diagnosis along with details of any ongoing treatment, including any current medications.

Section J - Exclusions

In accordance with the terms and conditions of the insurance policy the Insurer may impose waiting periods depending on the level of risk ranging from 3 (three) months waiting period to a lifelong exclusion on new applications. The insurer may decline a new application depending on the level of risk. The policyholder hereby acknowledge his/her understanding of the policy terms and conditions and agree to the applicable waiting period and exclusion that may be imposed.

Signature of Policyholder	

BENEFICIARY REGISTRATION OR TERMINATION / OPTION CHANGE / BANK DETAIL CHANGE FORM

Section K - Documentation *(The following documentation should be certified / *verified copies to accompany the application form.)*

ID / Passport of Applicant		Birth certificate / proof of guardianship of child / (full birth certificate)	
Proof of banking details (Kindly attach confirmation from the bank not older then 3 months)			
Payslip or other proof of income		Medical certificate for mentally / physically disabled children over 21	
Marriage certificate when registering a spouse / ID / Passport of spouse / Declaration of cohabitation		Proof of source of funds	

*Verified Copy

In terms of the Financial Intelligence Act, 2012 (Act 13 of 2012) (FIA) in compliance with 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 FIA.

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

Section L - 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. Kindly 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 kindly feel free to contact the Client Services Department at Tel: +264 83 2999 000 or email: life@prosperitynam.com

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.

BENEFICIARY REGISTRATION OR TERMINATION / OPTION CHANGE / BANK DETAIL CHANGE FORM

Section M - Financial Intermediary Review *(To be completed if adding a new beneficiary or adding a new policy.)*

The Policyholder hereby acknowledges his/her understanding of the below.

1. The Policyholder confirms that he/she was assisted in person/telephonically by the financial intermediary.	2. The Policyholder confirms that the policy was explained and that he/she understands the policy and the benefits applicable.
3. The Policyholder confirms that he/she was asked to declare any medical condition and/or previous treatment received prior to joining date.	4. The Policyholder confirms that he/she understands that exclusions and/ or waiting period may be imposed by the of the fund inclusive of any pre-existing conditions that were not declared upon joining.

5. The Policyholder understands that any treatment may be declined in the event that a pre-exiting condition was not declared upon application.

Policyholder Signature		Date	D	D	M	M	Y	Y	Y	Y

Why are we requesting the information from you?

The Namibian Financial Intelligence Act, No 13 of 2012 read with its Amendment Act, No 6 of 2023 (the "FIA Legislation"), requires us to ascertain the identity of our Policyholder, beneficiaries and/or Beneficial Owners of the policy and to maintain proper record of such persons.

Confidentiality

Your confidential information is stored securely within Namibia. We may disclose your personal information to our employees or representatives or when required, experts engaged by us, directly concerned with this mandate. However, we undertake all reasonable steps to ensure that they have the necessary privacy policies in place. We may also disclose your information where we have a duty or a right to disclose same, in terms of applicable legislation, court order, industry codes or where it may be necessary to protect our rights. We are bound by our policies and professional standards and Prosperity Lifecare and its employees maintain complete independence in relationship to policyholders.

To protect the integrity of your information, no amendments to any information provided to us will be accepted without written confirmation from yourself or an authorised representative.

Section N - Prominent Influential Persons ("PIPs") as per the FIA Legislation.

PIPs are persons holding a prominent public position or function, whether in Namibia or a foreign country or entrusted with a prominent position by an International Organization. In the event that you are a family member, close associate or a nominated beneficiary of a policy held by a PIP or for the benefit of a PIP, you are also considered a PIP. Should you be unsure whether you or your proposed beneficiary is a PIP, kindly inform the authorized employee assisting you at your nearest Prosperity Office or your financial intermediary, to provide clarity in this regard.

Are you a PIP?	YES		NO	
Are you the contact person of, or close associate of or family member of a PIP?	YES		NO	

Should you have answered "yes" to any of the above, please provide a brief description of the reasons for your answer and kindly stipulate the requisite source of funds and/or source of income.

Section O - Declaration by Financial Intermediary

1	I confirm that I have ascertained and verified the identity of the proposed Policyholder where relevant, as required by Financial Intelligence Act and the regulations thereto.
2	I confirm that I have, in addition, seen the identity document or passport of the proposed Policyholder and herewith declare that the information contained therein coincides with the details provided as part of the application process.

Signed at		on this		day of		2	0	Y	Y

Financial Intermediary Name	
Financial Intermediary Signature	
NAMFISA Reference Number (Where Applicable)	

BENEFICIARY REGISTRATION OR TERMINATION / OPTION CHANGE / BANK DETAIL CHANGE FORM

Section P - Acknowledgement

1. I acknowledge that the information provided and the details which have been completed on this form are correct and that I have the necessary authority to sign this document.
2. I herewith consent to the capturing, storage and recording of information as provided electronically on a computer, Prosperity's 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. I additionally consent to the processing and storage of my 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.
3. I acknowledge that I have the right to request and to have directly submitted to me, upon due request , a copy of any documentation that is submitted by or on my behalf to the Insurer.
4. And, I herewith indemnify Prosperity 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.

Policyholder Name		Date	D	D	M	M	Y	Y	Y	Y
Policyholder Signature										
Prosperity Lifecare Representative Name		Date	D	D	M	M	Y	Y	Y	Y
Signature										

Office Use Only

1	I herewith confirm that this form has been reviewed against the FIA Legislation and all persons referenced on this form have been screened against the United Nations Security Council's Sanctions List, as required by the Prevention and Combating of Terrorist and Proliferation Activities Act, No 4 of 2014 read with its Amendment Act, No 8 of 2023 ("PACOTPAA Legislation")

Signed at		on this		day of		2	0	Y	Y
Prosperity Lifecare Representative Name									
Signature									

Office Use Only

1	I confirm that I have diligently reviewed this form in compliance with FIA Legislation. Enhanced Due Diligence (EDD) processes, inclusive of Screening against the United Nations Security Council's Sanctions List, was conducted. I hereby approve the Prominent Influential Person Status.

Signed at		on this		day of		2	0	Y	Y
Principal Officer Name									
Signature									

NOTES: