APPLICATION FORM

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

hospicash
PRIVATE HOSPITAL FINANCE PLAN

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)

Office Use Only

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

Insurer Notes:

1	
2	
3	

Section A - Applicant Details

*Source of Income	Salary		Private Business		Other										
*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						
Marital Status	Single		Married		Divorced		Widowed		Cohabitation						
Proposed Joining Date	D	D	M	M	Y	Y	Y	Y							

Complimed PSEMAS Policyholder

*YES		NO		*Member Number											

Section B - Employment Details *(Kindly tick appropriate box)*

Private			CB Number						

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

I.D. / Passport no	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
				F	M	D	D	M	M	Y	Y

Underwritten by PROSPERITY LIFE

HOSPICASH APPLICATION FORM

Section D - Policy Optional Selection

Kindly mark with an (X) if cover is required.			Effective Date
HospiCash 50		***(For Complimed PSEMAS Policyholder)***	D D M M Y Y Y Y
HospiCash 100			D D M M Y Y Y Y
***Funeral Select Policy**			D D M M Y Y Y Y
***Funeral Standard Policy**			D D M M Y Y Y Y

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

Name	Surname	I.D. / Passport Number	Relationship

Section F - Bank Details *(For Debit Order Contributions or EFT Claim Refunds)*

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.)

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

I hereby authorize Prosperity Lifecare Insurance Limited to initiate premium deductions from my bank account 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 account.

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

Section G - Documentation *(The following documents are to be submitted together with the Application Form.)*

In terms of the FIA Legislation, the documents marked with an * must be certified or verified. Financial Intermediaries and authorized employees may verify a copy against the original document.

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

Identification and Verification in terms of FIA Legislation

I hereby confirm that information provided to me by the Applicant has been verified in compliance with the FIA Legislation and the identity of the Applicant established.

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

HOSPICASH APPLICATION FORM

Section H - Medical History

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**.

			Answer	
Non-disclosure of information may result in termination of policyholder 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.**			**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.		

HOSPICASH APPLICATION FORM

Section H - Medical History

			Answer	
Non-disclosure of information may result in termination of policyholder 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.**			**Yes**	**No**
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?		
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 the answer to any of the above questions is "yes", kindly give a comprehensive summary.

Section I - 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 Applicant 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 Applicant	

HOSPICASH APPLICATION FORM

Section J - Declaration by Policyholder

In this declaration the singular shall imply the plural.

1	I the undersigned, hereby apply for myself and my beneficiaries to join as a Policyholder of Prosperity Lifecare Insurance Limited.
2	I declare that this application and declaration together with any statements or representations made by myself, whether in writing or otherwise, are true and correct and I agree that such statement(s) or representation(s), together with any forms, reports or other information completed or supplied by myself, or any other requisite party on my behalf, inclusive of PSEMAS, any other medical aid or medical insurer of which I was a member and any service provider shall form the basis of this agreement and any underwriting effected in regard to my application, in respect or myself or my beneficiary(ies).
3	I agree on behalf of myself and my beneficiaries, to be bound by and to abide to the standard Terms and Conditions and any Rules ordinarily utilised by Prosperity Lifecare Insurance Limited. Prosperity Lifecare Insurance Ltd shall not be bound in any manner by any misrepresentations or undertakings made or given by any person, broker or agent.
4	It is further agreed and understood that, notwithstanding any statements made to the contrary by any person, the policy will not commence and no liability whatsoever will attach to Prosperity Lifecare Insurance Limited unless express written notice of acceptance of risk is given by Prosperity Lifecare Insurance Limited.
5	It is also agreed and understood that the policy will only commence on the 1st day of the month following receipt of payment by Prosperity Lifecare Insurance Limited.
6	I irrevocably authorise and provide informed consent on behalf of myself and beneficiary(ies) as the context permits, any medical practitioner, hospital, medical institution, pathology laboratory or other relevant person to disclose information which may be related to my occupation, physical or mental health, inclusive of the results of any tests to Prosperity Lifecare Insurance Limited and I agree that this authorisation shall remain in force after my death.
7	I indemnify Prosperity Lifecare Insurance Limited and it's creditors, agents and employees against any claim of whatever nature, which may be made against them as a result of or arising out of disclosure, medical information or any costs incurred as a result of being a policy holder of the Insurer.
8	I further accept that the provisions of any declaration made have been read and understood by me and will also apply mutatis mutandis to and form part of this application.
9	I authorise Prosperity Lifecare Insurance Limited to debit my bank account, details of which have been provided to Prosperity Lifecare Insurance Limited, for any amount due in terms of the policy applied for.
10	I undertake to advise Prosperity Lifecare Insurance Limited of any change in the status of health of myself, or any of my beneficiaries, which occurs prior to my receiving acceptance of this policy.
11	I declare that no material fact(s) have been withheld, misstated or concealed by myself or in respect of my beneficiaries and that I herewith unequivocally undertake to disclose all material facts prior to acceptance of the risk and I agree that any misrepresentation, misstatements and / or omission(s) of any material information, particularly in so far as it relates to disclosure of medical information pertinent to risk, will render my policy null and void.
12	I hereby acknowledge that any credit extended by Prosperity Lifecare Insurance Limited to myself or my dependants whilst being a Policyholder of Prosperity Lifecare Insurance Limited, will become payable in full upon termination of this policy at Prosperity Lifecare Insurance Limited and that interest may be charged on all amounts owing to Prosperity Lifecare Insurance Limited.
13	I further acknowledge that on termination of this policy, any amounts owing to the Insurer will be deducted from any amounts due to me by my Employer. For this purpose I hereby permit Prosperity Lifecare Insurance Limited to advise my Employer of any amounts due to Prosperity Lifecare Insurance Limited.
14	I acknowledge that Annual benefit and premium reviews will done at the end of each benefit year and premiums increased at the beginning of each benefit year, without the written consent of the premium payers.
15	I understand that any changes to this document as well as the policy status of myself or any of my beneficiaries will require the completion of the necessary forms.
16	I hereby acknowledge that I have included my current salary advice / 3 month bank statement as well as declared my current Insurance and the reason for it.
17	I hereby acknowledge that I understand the process and that over and under Insurance was explained to me.
18	I hereby acknowledge that I understand that there is a maximum cover per insured life.
19	I understand and agree to all the above:
20	The Policyholder hereby acknowledges his / her understanding of the below: • The applicant was in fact assisted in person / telephonically by the financial intermediary. • The applicant was given a thorough understanding of the policy and the insured covered. • The applicant was asked to declare any previous treatment received in the last 24 months prior to joining date. • The applicant 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. • The applicant 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.

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

HOSPICASH APPLICATION FORM

Section K - 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 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 Applicant 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 Applicant 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 Applicant 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 Applicant to the Insurer in as far as same applies to the policyholder.
8. In compliance with the Prevention of Organised Crime Act, No 29 of 2004 as amended, the Applicant confirms that the funds 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 Applicant additionally avails themselves to provide, upon request, any added clarity or documentation as may be required by the Insurer to ensure the legality of the source of the funds.
9. The Applicant 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 Applicant 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 Applicant 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 M - Declaration by Financial Intermediary

1	I hereby confirm that information provided to me by the Applicant has been verified in compliance with the FIA Legislation and the identity of the Applicant established.
2	I confirm that I have, in addition, seen the identity document or passport of the proposed Applicant 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)									

HOSPICASH APPLICATION FORM

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										