MEMBERSHIP RECORD AMENDMENT FORM

GEMHEALTH MEDICAL AID SCHEME

Tel: +264 83 2999 000
E-mail copy of completed form to: clientservices@prosperitynam.com

Section A - Employment Details *(Please tick appropriate box.)*

Member Number		Active Employee		Pensioner	
Company Name					
Nature of Industry				CB Number	
Company Address					
Telephone Number		Postal Address			
Employee Number		Date of Employment	D D M M Y Y Y Y		
Designation of Employee					

Section B - Member Details

Title		Initials		Full Names											
Surname															
Physical Address															
Postal Address												Postal code			
Telephone no	Home									Work					
Cellphone										Fax					
E-mail															
Date of Birth	D D M M Y Y Y Y								Age		I.D. / Passport no				
Copy of ID/Passport book to be attached to the application form - legally required															
Marital Status		Single		Married		Divorced		Widowed		Common Law					

Section C - Bank Details

Claims Refund		Contribution payments			
Debit Order Date	1st of every month		26th of every month		
Name of Account Holder		Bank Name			
Account Number		Branch Code			
Type of Account	Cheque		Transmission		Savings		Signature of Account Holder	

Section D - Member - Advise of Change in Marital Status *(Please tick appropriate box. When applicable attach copy of marriage/ ID/ Passport/divorce papers.)*

Married		Divorced		Widowed	
My spouse is not a member of another Scheme		My spouse is employed (Name of Company)			
My spouse is a member of a Registered Medical Scheme - Name of Scheme			Membership no.		
Title		Initials		New Surname (if applicable)	
Date of marriage/divorce/death	D D M M Y Y Y Y				

Section E - Registration

Registration of new born child &/or adopted children under the age of 21 years &/or deletion of dependant(s) due to death, divorce, child self supporting etc.

DEP CODE	FULL NAMES	DATE OF BIRTH			BENEFIT DATE			A	B	TERMINATION DATE		
		Day	Month	Year	Day	Month	Year			Day	Month	Year

Note: 1) Incase of adoption, copies of the adoption papers must accompany this form.
2) State reason for registration or termination of the above dependant(s).
3) In case of birth, copies of the birth certificate must be attached.

CODES
A - Relationship (S - Spouse) (C - Child)
B - Gender (F - Female) (M - Male)

Reason for registration/termination	

Section F - Medical History

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

			Answer	
Non-disclosure of information may result in termination of membership of non-payment of some medical treatment. Have you / your spouse or any one of your beneficiaries ever experienced any of the following? **Please 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.		
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 dependants ever been hospitalised? If yes, how frequently.		
18	Treatment & Surgery	Are you, your spouse or any dependants 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 dependants 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 dependants 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 dependants 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", please give a short summary.

I declare that to the best of my knowledge the information given above is true and correct

Member's signature		Date	D	D	M	M	D	D	D	D

Section G - To be Completed by Employer:

Name of Company		Effective Date	
Monthly contributions	**N$**		
Management Representation			Employer Stamp
Name			
Designation			

Signature		Date	D	D	M	M	Y	Y	Y	D