AMENDMENT / OPTION TRANSFER / EFT / REGISTRATION FORM

PROSPERITY LIFE

Tel: +264 61 2999 543
E-mail copy of completed form to: lifemember@prosperitynam.com

Section A – Employment Details *(Please tick appropriate box)*

Private		Company		Membership Number	
Company Name					
Nature of Industry				CB Number	
Company Physical Address					
Telephone number		Postal Address			
Employee number			Date of Employment	D D M M Y Y Y Y	
Designation of Employee					

Section B – Principal Member Details *(Attach copy of ID)*

Joining Date	0	1	M	M	Y	Y	Y	Y				
Title		Initials		Full Names								
Surname												
Physical Address												
Postal Address									Postal code			
Telephone number	Home					Work						
Cellphone number						Fax number						
E-mail Address												
Date of Birth	D	D	M	M	Y	Y	Y	Y	Age		I.D. / Passport no.	
Marital Status		Single		Married		Divorced		Widowed		Common Law		

Section C – Bank Details *(Attach proof of bank account details)*

Premium payments			Claims Refund				
Debit Order Date	1st of every month		20th of every month		25th of every month		
Name of Account Holder				Bank Name			
Account Number				Bank Branch Code			
Type of Account	Cheque		Transmission		Savings		Signature of Account Holder	

Section D – Product Option Selection / Change of Savings Cover (Medical Insurance Plans) *(Please tick appropriate box)*

Please indicate with an (X) in the appropriate block which cover you wish to select or if you wish to remain on the same option.

Humanity D1H		Effective Date	D	D	M	M	Y	Y	Y	Y	
Hospital Plan		Day-to-day Plan		Essential Health							

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Please indicate with an (X) in the appropriate block which cover you wish to select or if you wish to remain on the same option.

Executed		Effective Date	D	D	M	M	Y	Y	Y	Y									
Additional Savings Option - *Choose level of cover*		Level 1 *N$ 1,000*		Level 2 *N$ 2,000*			Level 3 *N$ 3,000*			Level 4 *N$ 4,000*			Level 5 *N$ 5,000*					
Oxygen		Effective Date	D	D	M	M	Y	Y	Y	Y									
Day-to-day Benefit Savings - *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$ 2,000*			Level 8 *N$ 3,000*			Level 9 *N$ 4,000*			Level 10 *N$ 5,000*					
Benefit Extender Cover *(Minimum level 1 Day-to-day Benefit Savings is required to apply for the Benefit Extender cover.)*		Effective Date	D	D	M	M	Y	Y	Y	Y									
		Medical Services		Level 1 *N$ 4,000 per person N$ 12,000 per family*			Level 2 *N$ 8,000 per person N$ 24,000 per family*			Level 3 *N$ 12,000 per person N$ 36,000 per family*									
		Medication																	
		Dental																	
Blue Cross		Effective Date	D	D	M	M	Y	Y	Y	Y									
Day-to-day Benefit Savings - *Choose level of cover*		Level 1 *N$ 200*		Level 2 *N$ 300*			Level 3 *N$ 400*			Level 4 *N$ 500*									

Section E – Product Option Selection (Add on products)

Please indicate with an (X) in the appropriate block which cover you wish to select or if you wish to remain on the same option.

Funeral Plan		Funeral PLUS Plan		Complimed Plus		Combo 3-in-1		* Rescue Me	

*** Only applicable to group schemes. Salary advice should be attached.**

Section F – Registration/Termination

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
		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			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	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
		D D M M Y Y Y Y	D D M M Y Y Y Y			D D M M Y Y Y Y

Note: 1) In case 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 marriage, copies of the marriage certificate must accompany this form.
4) In case of birth, copies of the birth certificate must be attached.

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

Reason for registration/termination	

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Section G - Medical History *(Compulsory for registration of dependants.)*

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**.

	Non-disclosure of information may result in termination of membership or non-payment of some medical treament. Have you / your spouse or any one of your beneficiaries ever experienced any of the following? **Please mark (x) the relevant box.**	Answer	
		Yes	**No**
1	Are you or your dependants suffering from, or have suffered from any chronic or recurring illness of any serious ailments?		
2	Have you or your dependants received any medical attention of any nature (e.g. hospitalisation, operation, othrodontics, etc.) during the last 2 years?		
3	Are you or your dependants expecting to undergo any procedure, operation or receive any major dental treatment within the next 12 months?		
4	Are you or your dependants receiving any medical or dental treatment at present?		
5	Have you or your dependants received treatment, advice or counselling for HIV/AIDS or any sexually transmitted diseases?		
6	Are you, your spouse, or any dependants currently pregnant? Should the answer be "yes", when is the expected date of delivery?		

If the answer to any of the above questions is "yes", please give a short summary.

Section H – Declaration

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	Y	Y	Y	Y

Section I - To be completed by Employer

Name of Company		CB Number								
Management Representation Name		Designation								
Signature		Date	D	D	M	M	Y	Y	Y	Y
Employer Stamp										