

FundsAtWork Namibia Declaration of health

Member number

Please fill in this form in the fields provided. Use the tab key to move from one field to the next.

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Section 1: Member details

Title Initial/s First name

Surname

Date of birth - -

National identity document Yes No Identity / Passport number

Passport country of origin

Telephone - work Fax

Telephone - home Cellphone number

Residential address

Postal Code

Postal address

Postal Code

Email address

Section 2: Underwriting

Hobbies

Do you participate or do you intend to participate in any pursuit or hobby that might be considered dangerous (eg aviation, diving, racing, parachuting, mountaineering)? Yes No

If Yes, please provide full details

Insurance history

Has an insurer ever declined, postponed or withdrawn any of your benefit/s applied for, or accepted them at an increased premium, or reduced the benefit/s applied for, or issued a benefit subject to an exclusion clause, or have you ever been medically boarded, or have you ever submitted claims for disability or third-party insurance benefits? Yes No

If Yes, please provide full details

Medical history

1. Heart or blood circulation

Do you have or have you previously had any heart or blood circulation complaints (eg high blood pressure, raised cholesterol, palpitations, heart attack, heart murmur, rheumatic fever, stroke, brain disorders or any cardiac procedures)? Yes No

Condition/impairment	Doctor's name	Currently on treatment?	Last symptoms	Fully recovered?
<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

2. Respiratory and/or lung complaints

Do you have or have you previously had any respiratory and/or lung complaints (eg asthma, bronchitis, tuberculosis, persistent coughing or any breathing problems)? Yes No

Condition/impairment	Doctor's name	Currently on treatment?	Last symptoms	Fully recovered?
<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Section 2: Underwriting (continued)

Medical history (continued)

3. Disorders of the digestive system, gall bladder, pancreas or liver

Do you have or have you previously had any disorders of the digestive system, gall bladder, pancreas or liver (eg hiatus hernia, gall stones, hepatitis A/B/C, jaundice, gastric ulcers or recurrent indigestion problems)?

Yes No

Condition/impairment	Doctor's name	Currently on treatment?	Last symptoms	Fully recovered?
<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/> M <input type="text"/> M - <input type="text"/> Y <input type="text"/> Y	Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/> M <input type="text"/> M - <input type="text"/> Y <input type="text"/> Y	Yes <input type="checkbox"/> No <input type="checkbox"/>

4. Disorders of the kidneys, bladder or reproductive organs

Do you have or have you previously had any disorders of the kidneys, bladder or reproductive organs (eg kidney stones, bladder infection, blood in urine, protein in urine or prostate problems)?

Yes No

Condition/impairment	Doctor's name	Currently on treatment?	Last symptoms	Fully recovered?
<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/> M <input type="text"/> M - <input type="text"/> Y <input type="text"/> Y	Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/> M <input type="text"/> M - <input type="text"/> Y <input type="text"/> Y	Yes <input type="checkbox"/> No <input type="checkbox"/>

5. Nervous or mental disorders

Do you have or have you previously had any nervous or mental disorders (eg depression, anxiety, consultation/s with psychiatrist/psychologist, stress, epilepsy, migraine or blackouts)?

Yes No

Condition/impairment	Doctor's name	Currently on treatment?	Last symptoms	Fully recovered?
<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/> M <input type="text"/> M - <input type="text"/> Y <input type="text"/> Y	Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/> M <input type="text"/> M - <input type="text"/> Y <input type="text"/> Y	Yes <input type="checkbox"/> No <input type="checkbox"/>

6. Disorders of the eye, ear, nose or throat

Do you have or have you previously had any disorders of the eye (excluding conditions corrected by glasses, contact lenses or keratotomy), ear, nose or throat (eg defective vision, hearing loss, hoarseness)?

Yes No

Condition/impairment	Doctor's name	Currently on treatment?	Last symptoms	Fully recovered?
<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/> M <input type="text"/> M - <input type="text"/> Y <input type="text"/> Y	Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/> M <input type="text"/> M - <input type="text"/> Y <input type="text"/> Y	Yes <input type="checkbox"/> No <input type="checkbox"/>

7. Problems with your spine, joints, bones, muscles, limbs or skin

Do you have or have you previously had any problems with your spine, joints, bones, muscles, limbs or skin (eg back problems, neck problems, fractures/broken bones, gout, arthritis, psoriasis, dermatitis)?

Yes No

Condition/impairment	Doctor's name	Currently on treatment?	Last symptoms	Fully recovered?
<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/> M <input type="text"/> M - <input type="text"/> Y <input type="text"/> Y	Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/> M <input type="text"/> M - <input type="text"/> Y <input type="text"/> Y	Yes <input type="checkbox"/> No <input type="checkbox"/>

8. Diabetes, raised blood sugar, other endocrine, glandular, blood or hormonal disorders

Do you have or have you previously had any form of diabetes, raised blood sugar, other endocrine, glandular, blood or hormonal disorders (eg thyroid or other gland problems, anaemia or bleeding disorders)?

Yes No

Condition/impairment	Doctor's name	Currently on treatment?	Last symptoms	Fully recovered?
<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/> M <input type="text"/> M - <input type="text"/> Y <input type="text"/> Y	Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/> M <input type="text"/> M - <input type="text"/> Y <input type="text"/> Y	Yes <input type="checkbox"/> No <input type="checkbox"/>

9. Any form of cancer, growth or tumour

Do you have or have you previously had any form of cancer, growth or tumour (including fibroadenomas, moles removed - both either malignant or benign)?

Yes No

Condition/impairment	Doctor's name	Currently on treatment?	Last symptoms	Fully recovered?
<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/> M <input type="text"/> M - <input type="text"/> Y <input type="text"/> Y	Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/> M <input type="text"/> M - <input type="text"/> Y <input type="text"/> Y	Yes <input type="checkbox"/> No <input type="checkbox"/>

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Section 2: Underwriting (continued)
Medical history (continued)

10. Drugs, tranquillisers or any other medicines

Are you taking or have you ever taken any drugs, tranquillisers or any other medicines in any form for any other reason than colds and flu (eg antidepressants, tranquillisers, homeopathic medicines, cannabis or cocaine)?

Yes No

Condition/impairment	Doctor's name	Currently on treatment?	Last symptoms	Fully recovered?					
<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<table border="1"><tr><td>M</td><td>M</td><td>-</td><td>Y</td><td>Y</td></tr></table>	M	M	-	Y	Y	Yes <input type="checkbox"/> No <input type="checkbox"/>
M	M	-	Y	Y					
<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<table border="1"><tr><td>M</td><td>M</td><td>-</td><td>Y</td><td>Y</td></tr></table>	M	M	-	Y	Y	Yes <input type="checkbox"/> No <input type="checkbox"/>
M	M	-	Y	Y					

11. Have you sought any medical advice during the last five years for any conditions or symptoms or have you been a patient in a hospital or nursing home, or undergone any medical examination (including but not limited to ECG, scans, x-ray examinations or specialised laboratory tests) not mentioned above?

Yes No

Condition/impairment	Doctor's name	Currently on treatment?	Last symptoms	Fully recovered?					
<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<table border="1"><tr><td>M</td><td>M</td><td>-</td><td>Y</td><td>Y</td></tr></table>	M	M	-	Y	Y	Yes <input type="checkbox"/> No <input type="checkbox"/>
M	M	-	Y	Y					
<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<table border="1"><tr><td>M</td><td>M</td><td>-</td><td>Y</td><td>Y</td></tr></table>	M	M	-	Y	Y	Yes <input type="checkbox"/> No <input type="checkbox"/>
M	M	-	Y	Y					

12. Have you ever been tested for, or received any medical advice, counselling or treatment in connection with AIDS, or any infection by one of the HI-viruses, or any sexually transmitted diseases (eg gonorrhoea, syphilis or genital herpes)?

Yes No

Condition/impairment	Doctor's name	Currently on treatment?	Last symptoms	Fully recovered?					
<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<table border="1"><tr><td>M</td><td>M</td><td>-</td><td>Y</td><td>Y</td></tr></table>	M	M	-	Y	Y	Yes <input type="checkbox"/> No <input type="checkbox"/>
M	M	-	Y	Y					
<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<table border="1"><tr><td>M</td><td>M</td><td>-</td><td>Y</td><td>Y</td></tr></table>	M	M	-	Y	Y	Yes <input type="checkbox"/> No <input type="checkbox"/>
M	M	-	Y	Y					

13. Are you aware of any other illness, disorder, disability or accident, including motor vehicle accidents or other factors (past or present) which may influence the insurance benefits?

Yes No

Condition/impairment	Doctor's name	Currently on treatment?	Last symptoms	Fully recovered?					
<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<table border="1"><tr><td>M</td><td>M</td><td>-</td><td>Y</td><td>Y</td></tr></table>	M	M	-	Y	Y	Yes <input type="checkbox"/> No <input type="checkbox"/>
M	M	-	Y	Y					
<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<table border="1"><tr><td>M</td><td>M</td><td>-</td><td>Y</td><td>Y</td></tr></table>	M	M	-	Y	Y	Yes <input type="checkbox"/> No <input type="checkbox"/>
M	M	-	Y	Y					

14. Do you have any intention of having medical investigations, procedures or check-ups done for any condition in the near future?

Yes No

Condition/impairment	Doctor's name	Currently on treatment?	Last symptoms	Fully recovered?					
<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<table border="1"><tr><td>M</td><td>M</td><td>-</td><td>Y</td><td>Y</td></tr></table>	M	M	-	Y	Y	Yes <input type="checkbox"/> No <input type="checkbox"/>
M	M	-	Y	Y					
<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<table border="1"><tr><td>M</td><td>M</td><td>-</td><td>Y</td><td>Y</td></tr></table>	M	M	-	Y	Y	Yes <input type="checkbox"/> No <input type="checkbox"/>
M	M	-	Y	Y					

For female applicants

15. Have you ever had or do you now have any disorder of the female organs (breasts, ovaries, uterus) or any abnormality of pregnancy or confinement (eg caesarean section, miscarriage or abortion)?

Yes No

Condition/impairment	Doctor's name	Currently on treatment?	Last symptoms	Fully recovered?					
<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<table border="1"><tr><td>M</td><td>M</td><td>-</td><td>Y</td><td>Y</td></tr></table>	M	M	-	Y	Y	Yes <input type="checkbox"/> No <input type="checkbox"/>
M	M	-	Y	Y					
<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<table border="1"><tr><td>M</td><td>M</td><td>-</td><td>Y</td><td>Y</td></tr></table>	M	M	-	Y	Y	Yes <input type="checkbox"/> No <input type="checkbox"/>
M	M	-	Y	Y					

Habits, measurements and family history

1. Habits

1.1 Have you smoked or used any other form of tobacco in the past six months? Yes No

If Yes, quantity per day?

1.2 Do you consume any form of alcohol? Yes No

If Yes, how many units per week (1 unit = 1 bottle of beer or 1 glass of wine or 1 tot of spirits/liquor)?

1.3 Have you ever received medical advice or participated in a rehabilitation programme to reduce alcohol and/or tobacco consumption? Yes No

If Yes, please provide full details

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Section 2: Underwriting (continued)

1.4 Are there any circumstances not disclosed above which may affect the risk of assurance on your life? Yes No

If Yes, please provide full details

2. Measurements

2.1 Height

 m

Weight

 kg

2.2 Has your weight changed by more than 5 kg during the last year? Yes No

If Yes, please indicate how much it has changed by kg, and why?

3. Family history

Has any family member suffered from any major illness or hereditary disorders (eg heart disease, raised cholesterol, high blood pressure, diabetes, cancer, depression, porphyria, polycystic kidneys) before the age of 60? Yes No

If Yes, please provide full details

Relation	Condition	Age diagnosed

Section 3: Medical doctor of the insured life

Please indicate the name of the doctor to whom Momentum may send the reasons for health loadings or results of an HIV test.

Confidential correspondence: Doctor (may not be a hospital)

Surname

Initial/s

Telephone - work

Fax

Postal address

Postal Code

Current/most recent doctor (if other than the above)

Surname

Initial/s

Telephone - work

Fax

When did he/she become your regular doctor?

D	D	-	M	M	-	Y	Y	Y	Y
---	---	---	---	---	---	---	---	---	---

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Section 4: Declaration by member

I accept and understand that I am limiting my right to privacy. To enable the assessment of the risks and the calculation of the premium and to assist in considering any claim for benefits as a result of this, I authorise Momentum Group Limited including their current and future subsidiaries and/or representatives:

- to obtain, share and disclose from any person, other insurer, medical aid, medical practitioner/institution, any information that Momentum requires for purposes of underwriting this application and or claims arising from this policy. I authorise such person/s to give the said information to Momentum;
- to share with other insurers as a group, at any time (even after my death) and in such detailed, abbreviated or coded form as Momentum or the operators of such database may decide from time to time; and
- to disclose my medical information to any parties that Momentum uses in providing services in connection with the policy.

I declare and confirm that:

1. To the best of my knowledge, all information that I have supplied is correct and complete.
2. Should any material information be withheld, incorrectly furnished or inaccurate, Momentum may cancel or restrict my cover in terms of the policy conditions.
3. Is prohibited in terms of the Long-term Insurance Act to sign a blank or incomplete form. I acknowledge and understand that Momentum and/or any of its subsidiaries, agents and/or authorised representatives will not be responsible for any damage or loss that I sustain as a result of signing this form before completing it in full.
4. I will inform Momentum in writing if a change takes place in my health, hobbies or occupation between the date of this form and either the starting date of the policy, or the acceptance date, until such time as Momentum may require further evidence of health. Failure to disclose these changes may result in the cancellation or restriction of the benefits in line with the policy conditions.

I understand that Momentum requires me to undergo an HIV test.

I indemnify Momentum against any consequent loss that dependants and beneficiaries or I may suffer as a result of the misuse, misapplication or misinterpretation of this communication.

Signed at

Signature of member

Date - - 2 0

Completed form together with supporting documents to be +264 61 299 7537 or emailed to fundsatworknamibia@momentum.co.na

When you sign this form by inserting a digital signature it confirms that the information provided is true and correct.

Options to sign the form:

1. Print out the form, sign and scan it and send it back via email to fundsatworknamibia@momentum.co.za or fax it to +264 61 234 851.
2. Place your scanned signature in the signature block.
 - Store your scanned signature in a safe place on your computer.
 - Select the 'comments' tab from your menu in Adobe.
 - Select the 'add stamp' icon.
 - Select custom stamps.
 - Create custom stamps.
 - You can now browse and upload your signature to save it as a custom stamp under 'sign here' in Adobe.
 - You can now go back to your 'stamps' icon and select 'sign here' and select your saved signature.
 - Place it in the document and save the document.

When you want to print the form to complete by hand you can turn off the field highlights by selecting the "highlight existing fields" on the top right hand corner of your screen.