



A MEMBER APPLICATION FORM
DISEASE MANAGEMENT FORM
ALL MEMBERS TO COMPLETE UPON FIRST CONSULTATION

Forward to: MyHealth Administrators, Maerua Office Park, Robert Mugabe Avenue, Windhoek
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Administrators of **Vitality** **Aids Outreach Programme** **Metropolitan Workplace Solution**
Private Medical Aid Funds Namibia Medical Care
RCC Bankmed Namibia
Renaissance Medical Aid
Employer Groups

1. Member Details

Member Surname..... First Name..... Date of birth.....
Identity Number..... Medical Aid.....
Medical Aid No..... Telephone Number(w)(.....)(h)(.....)
Cellphone Number..... Postal address.....

2. Member Consent

I wish to enrol myself/my dependant on the Disease Management Programme offered by MyHealth Administrators.

I authorise MyHealth Administrators to pay claims for medical treatment on my behalf. MyHealth Administrators shall use such funds for the treatment of the HIV condition of myself, or my dependant or both.

I understand that I will be liable for any claims relating to the medical costs related to the treatment of my HIV condition if there are no funds available to me on my withdrawal from the Disease Management Programme, or in the case of my death. This applies to my dependant too.

I hereby confirm that the information provided in this enrolment form is true and correct. I acknowledge that MyHealth Administrators is the administrator of the Case Management Programme and that any anti-retroviral treatment prescribed as well as the general management of any HIV condition shall be the sole responsibility of my medical practitioner. MyHealth Administrators and my employer shall accordingly not be liable for any claims by me or my dependants or any third parties, arising from the implementation of the Disease Management Programme.

I irrevocably give my consent to any medical practitioner, hospital, laboratory or any other person who may be in possession of any information concerning my health or my dependant's health, to provide MyHealth Administrators with such clinical information pertinent to my HIV management at MyHealth Administrators' request.

Whilst MyHealth Administrators shall use their best endeavours to uphold the confidentiality of all information disclosed to it, MyHealth Administrators shall not be liable for any claims by me or my dependants or third parties arising from any unauthorised disclosure of information pertinent to the management of my HIV infection to a third party. Nevertheless, owing to the complexity of HIV management, I authorise MyHealth Administrators to, when necessary, consult best international expertise in order to support my physician's management of my HIV, but on a strict proviso that neither my name nor any other form of my identification shall be made known to such international experts. This applies to my dependant too.

Patient's signature

Date

3. Doctor Details

Doctor Surname..... Initials.....
Practice Name..... Practice Number.....
Telephone Number (.....)..... Fax Number (.....)..... Cellphone Number.....
Postal address.....
E-mail address.....

Please fax this form to 061-375969.