ADD ON MEDICATION FORM

Tel: +264 61 201 2462

NAPOTEL
MEDICAL AID FUND

telecom namibia

nampost

Section A - Principal Member Details

Member Number		Employee Number	
First Name			
Surname			
Company			
Beneficiary Name			
Telephone Number			
Cellphone Number			
E-mail address			

Section B - Benefit Selection or Cancellation

Please indicate with an (X) in the appropriate block which cover you wish to select. Please choose one option per selected benefit only. Note that benefits are pro-rated as from joining date.

Effective Date	D	D	M	M	Y	Y	Y	Y	Cancellation Date	D	D	M	M	Y	Y	Y	Y

Medication												
Annual Benefit	3,600	5,400	7,800	9,600	12,000	15,000	19,200	24,000	26,400	31,200	38,000	
Monthly Premium	165	250	360	440	555	690	885	1,105	1,215	1,435	1,770	

Optical		Premium	Benefit			Dental	Premium	Benefit
Standard		165	2,260			Standard	392	5,330
Executive		253	3,390			Executive	628	8,528

Auxiliary		Premium	Benefit
Standard		253	3,390
Executive		336	4,520

Section C - Declaration by Principal Member

I, the undersigned hereby authorize the Napotel Medical Aid Fund to charge the above selected premium, in addition to my current monthly member premium. I further authorize my Employer to subtract the premium from my monthly salary and to pay it over on my behalf to the Fund if still employed or from my bank if I am a continuation member.

Signed at		on the		day of	
Signature		Print Name			

Section D - Human Resource Department

Name of Company		Effective Date	D	D	M	M	Y	Y	Y	Y
Name		Company Stamp								
Designation										
Signature of company representative										