CERTIFICATE OF COVER
Private Patients

Underwritten by Sanlam Namibia

1. DEFINITIONS

- **BENEFIT ANNIVERSARY DATE** means the date exactly one year from the effective date or the latest subsequent anniversary date.

i. **DEPENDANT** in regard to an INSURED means- the MEMBER's dependents as listed on his/her medical aid fund membership card. n the MEMBER for maintenance;

ii. is the spouse of the MEMBER, including a party to a customary union according to Black law and custom or to a union recognised as a marriage under the tenets of any Asiatic religion;

(a) a person in respect of whom the MEMBER would have become legally liable for maintenance, had the MEMBER not died;

and listed as such on the application form.

- **EFFECTIVE DATE** shall mean the first day of the month following receipt of the first premium in the books of the INSURER. In the event that an arrear payment is received, the EFFECTIVE DATE shall be the date of receipt of the arrear premium in the books of the FUND.
- **FUND** means the KHOMAS LOYALTY FUND, a permanent fund established within the meaning of par (d) of the definition of "fund" in Section 1 of the Long-term Insurance Act (Act 5 of 1998) for purposes of providing benefits to its members, their spouses and children, or to surviving spouses and/or children of deceased members.
- **INSURED** means a person who is insured by virtue of being a MEMBER of the FUND, or a DEPENDANT of such MEMBER nominated as such in writing by the MEMBER to the FUND.
- **LABORATORY** means a laboratory registered as such in terms of the relevant Namibian legislation and who has entered into a Service Level Agreement with the SERVICE PROVIDER.
- **MEDICAL PRACTITIONER** means a medical practitioner registered as such in terms of the relevant Namibian legislation, who is:

(a) practicing under the name and style of the SERVICE PROVIDER; or

(b) practicing under the name and style of any authorised third party service provider who has entered into a Service Level Agreement with the SERVICE PROVIDER, as communicated by the SERVICE PROVIDER from time to time.

- **MEDICAL CONSULTATION** means a consultation for medical advice/diagnosis with a MEDICAL PRACTITIONER.
- **MEMBER** means a person who is a member of the FUND, by virtue of being a Private Patients Card Holder.
- **MONTH** means any of the 12 (twelve) periods in which a year is divided.
- OPTOMETRIST means a optometrist registered as such in terms of the relevant Namibian legislation, who is:

(a) practicing under the name and style of the SERVICE PROVIDER; or

(b) practicing under the name and style of any authorised third party service provider who has entered into a Service Level Agreement with the SERVICE PROVIDER, as communicated by the SERVICE PROVIDER from time to time.

- **PHARMACY** means a pharmacy registered as such in terms of the relevant Namibian legislation and who has entered into a Service Level Agreement with the SERVICE PROVIDER, as communicated by the Service Provider from time to time, and **DISPENSARY** shall have a corresponding meaning.
- **SANLAM** means Sanlam Namibia Limited, registration number 95/301, and **INSURER** shall have a corresponding meaning.
- **SERVICE PROVIDER** means Khomas Medical Centre ("KMC"), consisting of Khomas Medical Centre Partnership, Khomas Medical Centre Auas Hills CC and Khomas Medical Centre Mondesa CC, who has entered into a Service Level Agreement

with the SERVICE PROVIDER to provide the benefits to MEMBERS of the FUND, either through its own branches or through authorised third party service providers, as advised by the SERVICE PROVIDER to the FUND and the INSURER from time to time.

2. PARTICIPATION

1.1. Insured

1.1.1. Every MEMBER qualifies to become an INSURED, provided that:

(a) he/she is a Private Patients Card Holder;

(b) he/she has applied for membership to the FUND in writing, and the FUND has approved such membership and has notified the INSURER accordingly;

(c) he/she has not reached the age of 65 (sixty five) years at the time of the application.

1.1.2. The insurance of a MEMBER who is insured in accordance with the preceding sub-clause, commences on the 1st (first) day of the month following receipt of the first premium in the books of the FUND. In the event that an arrear premium is received, the effective date shall be the date of receipt of the arrear premium in the books of the FUND.

1.1.3. The INSURER shall not be liable for any damage caused by any act, advice, negligent or otherwise, by the SERVICE PROVIDER or any contracted third party service provider in providing the benefits in terms of the insurance benefit.

1.1.4. The INSURER does not guarantee any medical expertise in respect of the appointed SERVICE PROVIDER or any authorised third party service provider who has entered into a Service Level Agreement with the SERVICE PROVIDER.

1.2. Termination of participation of an insured:

An INSURED ceases to be an INSURED –

(a) upon the INSURED's death; or

(b) upon the INSURED ceasing to be a MEMBER of the FUND;

(c) upon cancellation of the insurance benefit by the FUND or the INSURER;

(d) upon premiums falling into arrears for a period of more than 3 (three) months.

1.3. General exclusions

Claims will be repudiated on the following grounds:

(a) If the MEMBER's premiums payable to the FUND are in arrears;

(b) If the DEPENDANT in respect of whom the claim is submitted is not listed on the application form.

3. MEDICAL CONSULTATIONS

In consideration of the INSURED having paid the agreed premium to the FUND and subject to the terms, conditions and exclusions as set out in this Certificate of Cover, the INSURER offers the MEDICAL CONSULTATIONS benefit at a SERVICE PROVIDER as described in this Schedule, limited to a maximum of 15 (fifteen) medical consultations for every 1 (one) year cycle calculated from the EFFECTIVE DATE or BENEFIT ANNIVERSARY DATE

as the case may be.

In the event that the INSURED requires a consultation prior to the completion of 1 (one) year, the benefits shall be calculated on a pro rata basis from the 3rd (third month after the EFFECTIVE DATE.

3.1. Specific exclusions

No claim will be paid if:

(a) the DEPENDANT in respect of whom the claim is submitted is not listed on the application form;

(b) a claim is submitted within the first 3 (three) months after date of payment of first premium.

3.2. Claims procedures

3.2.1. In the event that the INSURED or his/her listed DEPENDANT(S) require a consultation with a MEDICAL PRACTITIONER, the INSURED or the DEPENDANT can attend any branch of any MEDICAL PRACTITIONER as communicated by the SERVICE PROVIDER from time to time and submit his/her Private Patients Card together with a copy of the INSURED's identity document.

3.2.2. The MEDICAL PRACTITIONER shall provide the INSURED or his/her DEPENDANT with a MEDICAL CONSULTATION in accordance with the terms and provisions of this Certificate of Cover.

3.2.3. The INSURED shall be liable for payment of the facility fee applicable at the relevant MEDICAL PRACTITIONER.

4. LABORATORY TESTS

In consideration of the INSURED having paid the agreed premium to the FUND and subject to the terms, conditions and exclusions as set out in this Certificate of Cover, the INSURER indemnifies the INSURED against the cost of laboratory tests.

4.1. Laboratory tests

4.1.1. The benefit is only applicable to referrals for specified laboratory tests by MEDICAL PRACTITIONERS as advised by the SERVICE PROVIDER from time to time, subsequent to a MEDICAL CONSULTATION at any such MEDICAL PRACTITIONER and done at any designated LABORATORY, within 7 (seven) days of issue of the referral.

4.1.2. The benefit is only applicable to the laboratory tests as advised by the INSURER from time to time, as communicated by the SERVICE PROVIDER from time to time.

4.1.3. The value of any claims under this benefit is limited to N$1500.00 per year per membership, and the balance (if any) will be for the account of the INSURED.

4.2. Specific exclusions

No claim will be paid if:

(a) the DEPENDANT in respect of whom the claim is submitted is not listed on the application form;

(b) a claim is submitted within the first 3 (three) months after date of payment of first premium.

4.3. Claims procedures

In the event that the INSURED or his/her listed DEPENDANT(S) is referred to undergo a laboratory test by a MEDICAL PRACTITIONER as per 4.1 above, the INSURED or the DEPENDANT can obtain these from any designated laboratory as communicated by the SERVICE PROVIDER from time to time, by submitting his/her Private Patients Card together with the script and a copy of the INSURED's identity document.

5. ACUTE GENERIC MEDICATION

In consideration of the INSURED having paid the agreed premium to the FUND and subject to the terms, conditions and exclusions as set out in this Certificate of Cover, the INSURER indemnifies the INSURED against the cost of acute prescription medicines.

Acute generic medication which contains the same active ingredients, is identical in strength, dosage form, and route of administration, has the same indications, dosing and labelling, and provides the same efficacy and safety profile to patients like the original branded name medication, will be prescribed for a disease with a rapid onset and/or a short course, in other words an acute disease and/or health problem.

5.1. Limitations

5.1.1. The benefit is only applicable to scripts written by MEDICAL PRACTITIONERS during a MEDICAL CONSULTATION at any authorised MEDICAL PRACTITIONER and filled at any one of the designated PHARMACIES as advised by the SERVICE PROVIDER from time to time, within 7 (seven) days of issue.

5.1.2. The benefit is limited to 1 (one) script per MEDICAL CONSULTATION in terms of this benefit.

5.1.3. The value of a claim under this benefit is limited to N$150.00 per claim, and the balance (if any) will be for the account of the INSURED.

5.2. Specific exclusions

No claim will be paid if:

(a) a claim is submitted within the first 3 (three) MONTHS after date of payment of first premium;

(b) the DEPENDANT in respect of whom the claim is submitted is not listed on the application form.

5.3. Claims procedures

5.3.1. In the event that the INSURED or his/her listed DEPENDANTS obtain a script from a MEDICAL PRACTITIONER, the INSURED or the DEPENDANT can obtain these from any designated PHARMACY as communicated by the SERVICE PROVIDER from time to time, by submitting his/her Private Patients Card together with the script and a copy of the INSURED's identity document.

5.3.2. The dispensing PHARMACY shall provide the INSURED with the prescribed medicine in accordance with the terms and provisions of this Certificate of Cover.

6. OPTICAL BENEFITS

In consideration of the INSURED having paid the agreed premium to the FUND and subject to the terms, conditions and exclusions as set out in this FUND POLICY, the INSURER indemnifies the INSURED against certain optical costs.

6.1. Limitations

6.1.1. The benefit is only applicable to scripts written by OPTOMETRISTS during a CONSULTATION at any authorized OPTOMETRIST PRACTICE and filled at any one of the designated OPTOMETRIST PRACTICES as listed in Annexure B, within 7 (seven) days of issue.

6.1.2. The benefit is limited to 1 pair of spectacles/glasses per membership (main member + 4 dependents) every 2 years (24 months) as per the following:

Option A (Single Vision Base Package): N$650.00
(a) 1 Eye examination by a qualified optometrist;
(b) 1 (one) frame from a selected range;
(c) 1 (one) set of Single Vision lenses & Hard Coat.

Option B: (High Prescription Single Vision Package): N$850.00
(a) 1 Eye examination by a qualified optometrist;
(b) 2 x Single Vision Surfaced High Prescription + Hard Coat;
(c) 1 (one) frame from a selected range.

Option C: (Bifocal Package): N$1150.00
(a) 1 Eye examination by a qualified optometrist;
(b) 2 x Bifocal lenses + Hard Coat;
(c) 1 (one) frame from a selected range.

Loyalty Fund Member co-payments / upgrade options for options A, B or C
(a) N$ 600 upgrade to Flexi-Tint;
(b) N$ 500 upgrade to Anti-reflective coating;
(c) N$350 upgrade to Orange dot frame;

6.1.3. The value of a claim under this benefit is limited to N$650.00 per claim (Option A), and the balance (if any OR if Option B or C are chosen) will be for the account of the INSURED.

6.2. Specific exclusions

No claim will be paid if:
(a) a claim is submitted within the first 3 (three) MONTHS after date of payment of first premium;
(b) the DEPENDANT in respect of whom the claim is submitted is not listed on the application form.

6.3. Claims procedures

6.3.1. In the event that the INSURED or his/her listed DEPENDANTS obtain a script from a OPTOMETRIST, the INSURED or the DEPENDANT can obtain these from any designated OPTOMETRIST PRACTICE as per Annexure B, by submitting his/her Private Patient Card together with the script and a copy of the INSURED's identity document.

6.3.2. The dispensing OPTOMETRIST PRACTICE shall provide the INSURED with the prescribed benefit in accordance with the terms and provisions of this FUND POLICY.

7. FUNERAL BENEFITS

Upon the death of the INSURED and/or his/her DEPENDANT as listed on the application form, the INSURER will pay a funeral benefit as set out below, provided that the INSURED has kept all monthly premiums up to date for a period calculated from the date of payment of first premium or the BENEFIT ANNIVERSARY DATE, as the case may be:

Death of the INSURED	N$10,000.00
Death of a DEPENDANT	N$5,000.00
(subject to a maximum of 4 (four) dependants as listed on the application form.	

7.1. Specific exclusions

7.1.1. No claim will be paid if:
(a) a claim is submitted within the first 3 (three) MONTHS after date of payment of first premium;
(b) unless the claim is submitted to and received by the INSURER within a period of 90 (ninety) days of the death of the MEMBER and/or his/her DEPENDANT;
(c) the DEPENDANT in respect of whom the claim is submitted is not listed on the application form;
(d) if the MEMBER or DEPENDANT was over the age of 65 years at the date of joining.

7.1.2. Notwithstanding any other provision to the contrary in the Certificate of Cover, no benefit is paid in terms of this Schedule if the MEMBER'S or a DEPENDANT's death –
(a) is a direct or indirect consequence of active participation in war, invasion, acts of foreign enemies, hostilities, warlike operations (whether war be declared or not), civil war, rebellion, revolution, insurrection, civil commotion assuming the proportions of or amounting to an uprising, military or usurped power;
(b) is a direct or indirect consequence of-
(i) the use of nuclear, biological or chemical weapons, or any radioactive contamination; or
(ii) attacks on or sabotage of facilities (including, but not limited to, nuclear power plants, reprocessing plants, final repository sites and research reactors) and storage depots, which lead to the release of radioactivity or nuclear, biological or chemical warfare agents, irrespective whether any of the aforesaid has been performed with the specific use of information technology.

The onus of proof shall be on the beneficiary to show that none of the exclusions listed above were present or contributed to the cause of death.

7.2. Payment of benefit

(a) Claims for the funeral benefit will be paid within 48 (forty eight) hours of successful assessment by the INSURER.
(b) Benefits in terms of this Schedule will be paid to the FUND or directly to the INSURED MEMBER or his/her estate as per written instructions from the FUND.
(c) Any payment by the INSURER to the FUND or directly to the MEMBER or his/her estate in terms of this clause releases the INSURER from any further liability in relation to the benefits payable in terms of this Schedule. Neither the FUND nor the INSURED MEMBER, DEPENDANT, INSURED MEMBER's estate or any other person shall have any claim against the INSURER once the INSURER has made payment in accordance with this provision.

7.3. Claims procedures

7.3.1. A claim must be submitted by a beneficiary or interested party on the prescribed claim form to the FUND within 60 (sixty) days of the death of an INSURED or a DEPENDANT, and the FUND shall in turn submit the claim to the INSURER within 30 (thirty) days from receipt thereof by a beneficiary or interested party.

7.3.2. The INSURER shall not be liable to effect payment of any claim unless the following documents are submitted in support of such claim:
(a) A valid death certificate indicating the cause of death of the INSURED; and/or
(b) Any other documentation/ information reasonably necessary for the assessment of the claim by the INSURER.

8. PREMIUMS

8.1. Monthly premiums

8.1.1. In consideration for the FUND's obligations in terms of the Certificate of Cover, the INSURED is liable for a monthly premium to the FUND as set out in the Application Form.

If any premium in regard to an INSURED is not paid promptly in terms of the insurance benefit, the INSURER's liability to make any payment or to provide any benefit lapses, but the INSURER may reinstate its liability regarding the INSURED prior to such lapse on the conditions which it may lay down.

9. MISCELLANEOUS PROVISIONS

9.1. Commencement, duration of insurance and payment of premiums

9.1.1. The insurance cover shall commence on the EFFECTIVE DATE, and provided that the INSURED continues to pay the monthly premium, shall be effective until cancelled by the FUND or the INSURER or the INSURED in writing, in which event cover shall cease at 00h00 on the last day of the month for which premiums have been paid.

9.1.2. Premiums are payable by the INSURED to the FUND monthly in advance before the 1st (first) day of the MONTH for which cover is required. The onus is on the INSURED to ensure that the PREMIUMS are duly paid.

9.1.3. If arrear premiums are received in the books of the FUND, the INSURER shall have the right to indemnify the FUND or to regard the policy as having been cancelled and to refund the arrear premiums received.

9.1.4. Subject to clause 8.2, if this insurance cover is cancelled at any time for any reason the INSURED shall not be entitled to a refund of any premiums paid.

9.1.5. The FUND shall have the right to increase the monthly premium annually on 1 April.

9.2. Cooling off period

In the event that the INSURED cancels his/her participation within 2 (two) months of the application by the INSURED and provided that the INSURED did not prior to such cancellation submit any claim in terms of this insurance benefit, the FUND shall refund all premiums received from the INSURED.

9.3. Currency

All amounts payable to or by the parties in terms of this Certificate of Cover, are payable in the Republic of Namibia in the currency of the Republic of Namibia.

9.4. Disclosure of risk

The INSURED acknowledges that the insurance cover is entered into by the FUND and/or INSURER based on information disclosed to it by the MEMBERS, and that a failure to disclose any fact or circumstance which may arise while the policy is valid may affect the risk insured and may result in the repudiation of any claim submitted.

9.5. Confidentiality

All medical records remain in the custody and control of any SERVICE PROVIDER who will maintain and protect the doctor patient confidentiality at all times.

9.6. Whole agreement

The application for insurance shall be the basis of and forms part of this Certificate of Cover. The Certificate of Cover and amendments thereto and the application form shall constitute the whole agreement between the parties.

Signatories:

KLF representative

Member

Processed (Admin)

Please initial the front page

Khomas Loyalty Fund
Membership Application Form

Mar-20

PARTICULARS OF APPLICANT		PARTICULARS OF INSURED			
Surname:		Main Insured:			
First name(s):		ID or Date of Birth:			
Title:			Full Name & Surname	Date of birth	Gender
Physical address:		Dependants:	1)		M / F
Postal address:			2)		M / F
Town:			3)		M / F
Employer:			4)		M / F
Work No:		CURRENT MEDICAL AID DETAILS			
Email address:		Principal Member:			
Home:		Medical Aid Provider:			
Cell:		Medical Aid Number:			
Next of kin's cell:		Medical Aid Plan:			
Date of birth (main member)		Khomas Medical Centre File No:			
ID No (main member)		**The below nominated person will be entitled to my funeral benefit. (Nominee must be 18 years and older):**			
☐	If the person responsible for the payment is the Insured	Name:			
PAYEE		ID No:			
☐	If the person responsible for the payment is NOT the Insured.	Plan	Monthly Premium		
Relationship:		Top Up Silver (Individual)	N$125.00	☐	
☐	I wish to pay by salary stop order every month. Please arrange this with my employer.	Top Up Gold (Family)	N$150.00	☐	
Employer:		Private Patient	N$275.00	☐	
First deduction date:		I hereby certify that the particulars given above are true and correct and I understand that this application is subject to Sanlam Namibia Ltd's standard terms and conditions, as amended from time to time. Furthermore, I hereby certify that I apply for the insurance out of my own free will, without having been solicited to do so.			
Deduction date:	□ 5th □ 15th □ 20th □ 25th□31st □ 1st day of month				
☐	I wish to pay by bank debit order every month.	Signature:			
Account Holder:		Date:			
Account Number:		FOR OFFICE USE ONLY			
Account Type:		Card No:			
Branch Name & Code		First deduction date:			
Bank Name		Agent Code:			
Signature of Account Holder:					

KHOMAS MEDICAL CENTRE

Sanlam