ONAWAMED

MEMBERSHIP
APPLICATION FORM

OCTOBER 2024

Single ☐ Family ☐

CIF Number: ☐☐☐☐☐☐☐☐☐☐

Policy Number: ☐☐☐☐☐☐☐☐☐☐

PARTICULARS OF MAIN INSURED

Title: _____ Surname: _____ Maiden Name: _____

Full Name (s): _____ Passport No: ☐☐☐☐☐☐☐☐☐☐☐☐☐

Gender: Male ☐ Female ☐ Maritial Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

Nationality: Are you a Namibian citizen? ☐ Yes ☐ No If "No ☐ Domicle ☐ Work Permit ☐ Permanent Residence

Cell no: _____ Email: _____ Employer: _____

Occupation: _____ Telephone: (W) _____ (H) _____

Physical Address: _____

Postal Address: _____

Next kin's surname: _____ Full Name (s): _____

DOB/ID no: ☐☐☐☐☐☐☐☐☐☐☐☐☐ Cell: _____

Prominent Influential Person: ☐ Yes ☐ No

Designation: _____

Prominent Influential Person: ☐ Yes ☐ No

Relationship: _____

Method of Payment: ☐ Cash ☐ DO ☐ SO ☐ EFT **PAYER** ☐ If the person responsible for the payment is the Insured.

Source of income: _____

Gross individual monthly income: ☐ N$1 000 - N$5 000 ☐ N$5 000 - N$10 000 ☐ N$10 000 - above

PAYER Details *(If the person responsible for payment is NOT the insured)*

Relationship: _____ Surname: _____ Full Names: _____

DOB/ID No.: ☐☐☐☐☐☐☐☐☐☐☐☐☐ Email: _____

Physical Address: _____

Telephone number: (W) _____ (H) _____ Cell: _____

Employer: _____ Occupation: _____

Signature: _____

Source of income: _____

Gross individual monthly income: ☐ N$1 000 - N$5 000 ☐ N$5 000 - N$10 000 ☐ N$10 000 - above

Bank Details *(If the method of payment is Debit Order)*

Account Holder Name & Surname: _____ Name of Bank: _____

Account Number: _____ Branch Code: _____ Account Type: _____

☐ I wish to pay the above option by Debit Order from my bank account on the _____ day of every month.

Salary Details *(If the method of payment is Salary Order)*

Employer: _____ Salary No.: _____

HR Officer: _____ Preferred deduction date: _____

I hereby nominate the following beneficiary for my free funeral benefit:

Full Name (s): _____ Passport No.: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Cell: _____ Email: _____ Surname: _____

PARTICULARS OF INSURED

Main Insured: _____ DOB/ID no: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Spouse: _____ DOB/ID no: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Children:

1) _____ DOB: _____

2) _____ DOB: _____

3) _____ DOB: _____

*4) _____ DOB: _____

- *(if no Spouse)

FAMILY

Do you have any active product with us? ☐ Yes ☐ No

If yes, please provide details (policy number): _____

OnawaMed stand alone	☐ N$347
Hospital Benefit	☐ N$81
OnawaMed - Existing Trustco Product	☐ N$289

SINGLE

Do you have any active product with us? ☐ Yes ☐ No

If yes, please provide details (policy number): _____

OnawaMed stand alone	☐ N$208
Hospital Benefit	☐ N$81
OnawaMed - Existing Trustco Product	☐ N$173

I hereby certify that the particulars given above are true and correct and understand that this application is subject to Trustco Life Ltd. standard terms and conditions, as amended from time to time. ☐ Agree

Date: _____ Signature: _____

Ist Deduction: _____ Agent code: _____

Extension: _____ Time: _____

REFER A FRIEND

Name & Surname: _____ Name & Surname: _____

Contact details: _____ Contact details: _____

How do you prefer to obtain your card, contract & schedule:

Mail ☐

To be collected from office ☐

FOR INTERNAL USE ONLY: (Certified copy/verified copy)

ID ☐ ID Payee ☐ ID Dependant ☐ ID Beneficiary ☐ Passport ☐

Pay Slip ☐ Birth Certificate ☐ Marriage Certificate ☐ Bank Statement ☐

Non-Namibian: Permanent Residency ☐ Domicile ☐ Work Permit ☐

FOR INTERNAL USE ONLY:

	Yes	No	
Admin Fee	☐	☐	Date (if yes):_____
Written off	☐	☐	
Conversion	☐	☐	

COMMENTS (INTERNAL)

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