



We're about you

## Termination request

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Unit 2, Demushuwa Suites, Corner of Grove and Ombika Street,

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Reg No: MOHSS 003

**Please note** In order for the administrator to deliver efficient service to you, it is important that you provide and complete all information as required. Print clearly using **capital** letters. Only **one** character per block. Leave open **one** block between words. Mark with an **X** where necessary.

### Particulars of principal member (must be completed)

Membership number  Benefit option

Title  Initials  First name(s)

Surname

### Termination of membership (if applicable)

I hereby wish to terminate the above membership effective from

### Termination of dependant(s) (if applicable)

I hereby wish to terminate the following dependant effective from         Dependant code

Relationship to principal member  Spouse  Partner  Additional adult  Child

Title  Initials  First name(s)

Surname

### Reason for termination

Dependant is over 25 years  Dependant is over 21 years  Financial constraints  Deceased

Joining spouse's/partner's medical aid fund Fund name

Joining another medical aid fund Fund name

Other (please specify)

### Acknowledgment and declaration

I hereby give one calendar month notice period by signing this termination form and certify that the information provided herein is true and correct.

\_\_\_\_\_  
Signature of principal member

Date

Company stamp