Health *SmartCard*

METHEALTH NAMIBIA ADMINISTRATORS

Service Provider *Health* SmartCard User Application Form

Ref:……

Account Details (To be completed in Block Letters)

Practice Number:													

Practice Name:	
Postal Address:	
Physical Practice Address	Town:
Region:	Suburb:
Street Address:	
E-mail Address:	
Surname:	
First Names:	
Title:	
Work Phone: ( )	Fax: ( )
Cell Number:	
Preferred date of enrollment:	

User List: (Level : 1 - Main User 2 - Sub User) - (Main User can access payment details)

Name:	Surname:	USER ID /PASSPORT:	Access Level:
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

INDEMNITY CLAUSE

Whilst acknowledging that **Methealth Namibia Administrators (Pty) LTD.** and/or **NMC/Bankmed Namibia** will take all reasonable steps to ensure correctness of the Health SmartCard information, I hereby indemnify **Methealth Namibia Administrators (Pty) LTD.** and/or **NMC/Bankmed Namibia** against any claims of whatsoever nature arising in the event of a member/dependant(s) Health SmartCard information being incomplete or incorrect.

Signature:_____

Date: _____ / _____ / _____

Send to:
Health *SmartCard* **Department**
METHEALTH NAMIBIA ADMINISTRATORS
FAX: (+264 61) 287 6101/2/3
TEL: (+264 61) 287 6027
Toll FREE 0800 228877
E-mail: helpdesk@healthsmartcard.com.na

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For office use:

Enrolment Done by:_____

Date:_____

Signature:_____

Updated by:_____

Date:_____

Checked by:_____