ENGEN Medical Benefit Fund

Administered by Discovery Health

Contact details
Tel: 0800 001 615 • PO Box 652509, Benmore 2010 • www.engenmed.co.za

Application for registration of a newborn baby

Thank you for applying to register your newborn baby on your Engen Medical Benefit Fund membership. Please make sure you read and understand the terms and conditions for membership

Who we are

Engen Medical Benefit Fund (referred to as 'EMBF'), registration number 1572, is the medical scheme that you are applying to become a member of. This is a not-for-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, (referred to as 'the administrator') is a separate company, an authorised financial services provider and is responsible for the administration of your membership on behalf of the Fund.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. The main member must sign this application and date any changes.
3. Provision is made in this form for you and your dependants to provide information relating to your race. This information is required by the Council for Medical Schemes for statistical purposes only. You are not compelled to provide this information.
4. Submit the signed and completed document to your HR department and they will email it to **application@engenmed.co.za**.

When you sign this application, you confirm that you have read and understood the terms and conditions for membership and agree to them.
If you have any questions, please let us know. Once we have assessed the application, we will let you know if your baby has been accepted and what will happen next.

1. Main member's details

Membership number

ID or passport number

Member's name

Member's surname

2. Newborn's details

2.1 First name

Surname

ID Number

Gender M ☐ F ☐ Date of birth D D M M Y Y Y Y

Race African ☐ Coloured ☐ Indian / Asian ☐ White ☐ Other ☐ Do not want to disclose ☐

You are not compelled to provide the information required on race. The Fund is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

When do you want cover to start? D D M M Y Y Y Y

Is the newborn your biological child? Yes ☐ No ☐ or is the newborn adopted or fostered? Yes ☐ No ☐

If the newborn is adopted or fostered, please supply legal proof or an affidavit confirming that you are responsible for family care and support of the dependant.

2.2 First name

Surname

ID Number

Gender M [ ] F [ ] Date of birth D D M M Y Y Y Y

Race African [ ] Coloured [ ] Indian / Asian [ ] White [ ] Other [ ] Do not want to disclose [ ]

You are not compelled to provide the information required on race. The Fund is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

When do you want cover to start? D D M M Y Y Y Y

Is the newborn your biological child? Yes [ ] No [ ] or is the newborn adopted or fostered? Yes [ ] No [ ]

If the newborn is adopted or fostered, please supply legal proof or an affidavit confirming that you are responsible for family care and support of the dependant.

2.3 First name(s)

Surname

ID Number

Gender M [ ] F [ ] Date of birth D D M M Y Y Y Y

Race African [ ] Coloured [ ] Indian / Asian [ ] White [ ] Other [ ] Do not want to disclose [ ]

You are not compelled to provide the information required on race. The Fund is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

When do you want cover to start? D D M M Y Y Y Y

Is the newborn your biological child? Yes [ ] No [ ] or is the newborn adopted or fostered? Yes [ ] No [ ]

If the newborn is adopted or fostered, please supply legal proof or an affidavit confirming that you are responsible for family care and support of the dependant.

3. Parents' details

Mother's surname

Mother's first name

Father's surname

Father's first name

4. Birth details

1.Type of delivery? Normal vaginal delivery [ ] Caesarean section [ ] Vacuum delivery [ ] Forceps [ ]

2. Did the baby sustain injuries or experience complications at birth? Yes [ ] No [ ]

3. Was the baby born with birth defects or abnormalities? Yes [ ] No [ ]

4. Is there any other information you feel we should be aware of? Yes [ ] No [ ]

5. Declaration

I, ____________________ (first name and surname), the main member, request that the newborn baby/ies indicated on this form be added to my membership as registered dependant/s. I also confirm that all the information given here is true to the best of my knowledge.

Signed at (town or city) ____________________ on D D M M Y Y Y Y

Signature of main member

I confirm the information is accurate and complete.

This form must be signed by the main member only once it has been completed in full and the main member must sign and date any changes thereto.

6. Note to member

Please register your newborn baby with the department of Home Affairs within 21 days from birth and give us a copy of the birth certificate as soon as possible.

Approval from Employer

Name

Signature

Designation

Date D D M M Y Y Y Y