



DETAILS OF NEWBORN/CHILD

Account No: _____ (for office use)
First Name: _____ Surname: _____ Male/Female: _____
Date of Birth: _____ Individual Dependent Code at Fund: _____

Other Children on Our Records

Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____

MEDICAL AID DETAIL (if applicable)

AUTHORISATION NUMBER (if applicable):

Name of Fund: _____ Option: _____ Member Number: _____
Main Member: _____ ID Number: _____

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT

Title: _____ Initials: _____ Surname: _____
First Name(s): _____ ID Number: _____
Postal/Home Address: _____ Postal Code: _____

Email Address (for communication purposes):

Home Tel No: _____ Mobile (Mom): _____ Mobile (Dad): _____
Employer Name: _____ Work Address and Code: _____
Work Tel and Code: _____

CHILD'S MOTHER

Title: _____ Name: _____ Surname (if different): _____

CHILD'S FATHER

Title: _____ Name: _____ Surname (if different): _____

RELATIVE/FRIEND (That can be contacted in emergencies)

Name: _____ Relationship: _____ Tel and Code: _____
Address: _____

FAMILY DOCTORS

Referring Dr: _____ GP: _____

PARENT/GUARDIAN AGREEMENT

- I confirm that the above information is correct and agree to notify any change within 14 days and to supply new data accordingly.
- I take full responsibility for the account.
- I agree to pay all money not paid by my medical aid.

SIGNATURE _____

DATE _____