

Application for registration of newborn baby 2022

Thank you for deciding 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 Fund 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. Submit the signed and completed document to your HR department and they will fax this form to 011 539 3000 or email it to application@engenmed.co.za
3. Please make sure the main applicant signs this application and dates any changes.
4. Please attach a copy of your newborn baby's birth certificate.
5. 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 Scheme for statistical purposes only. You are not compelled to provide this information.

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	<input type="text"/>
ID or passport number	<input type="text"/>
Member's name	<input type="text"/>
Member's surname	<input type="text"/>

2. Newborn's details

2.1 First name	<input type="text"/>
Surname	<input type="text"/>
ID Number	<input type="text"/>
Date of birth	<input type="text"/>
Gender	<input type="text"/>
Race	African <input type="checkbox"/> Coloured <input type="checkbox"/> Indian / Asian <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/>
<i>You are not compelled to provide this information. The scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.</i>	
Do not want to disclose	<input type="checkbox"/>
When do you want cover to start?	<input type="text"/>
Is the newborn your biological child?	Yes <input type="checkbox"/> No <input type="checkbox"/>
or is the newborn adopted or fostered?	Yes <input type="checkbox"/> No <input type="checkbox"/>
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	<input type="text"/>
Surname	<input type="text"/>

ID Number

Day of birth Gender

Race African Coloured Indian / Asian White Other

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

Do not want to disclose

When do you want cover to start?

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

Date of birth Gender

Race African Coloured Indian / Asian White Other

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

Do not want disclose

When do you want cover to start?

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/s 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 and belief.

Signed at (town or city)

on

D	D	M	M	Y	Y	Y	Y
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Signature of main member

I confirm the information is accurate and complete.

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

6. Note to member

Please register your newborn 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

COMPANY STAMP

Signature

Designation

Date

D	D	M	M	Y	Y	Y	Y
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