

Application for registration of newborn baby 2019



Administered by Discovery Health

Contact us

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Thank you for deciding to register your newborn baby on your Remedi Medical Aid Scheme membership. Please make sure you read and understand the rules for membership.

Who we are

Remedi is the medical scheme, registration number 1430, which is registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to as "the administrator") is a separate company and an authorised financial services provider (registration number 1997/013480/07), which takes care of the administration of your membership of Remedi.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. Please make sure the main applicant signs this application and dates any changes.
3. Hand the completed and signed form to your employer contact.
4. Please attach a copy of your newborn baby's birth certificate.

When you sign this application, you confirm that you have read and understood the rules 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.

Please note:

For us to accept your newborn baby without any conditions, you must register your newborn baby within 30 days of his or her birth and cover must start from the date of birth. If you do not register your baby from the day he or she is born, you have to pay backdated contributions.

If you are applying after 30 days from the birth of your newborn baby or you want the cover to start on any other day after the date of birth, we may apply

certain conditions to your baby's membership on Remedi Medical Aid Scheme. You will need to complete a different application called "Application to add a dependant to Remedi Medical Aid Scheme".

1. Main member's details

Membership number	<input type="text"/>
ID or passport number	<input type="text"/>
Member's surname	<input type="text"/>
Member's name	<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"/>	When do you want cover to start?	<input type="text"/>

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 of adoption or foster care arrangement.

2.2 First name	<input type="text"/>				
Surname	<input type="text"/>				
ID number	<input type="text"/>				
Date of birth	<input type="text"/>	Gender	<input type="text"/>	When do you want cover to start?	<input type="text"/>

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 of adoption or foster care arrangement.

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2. Newborn's details (continued)

2.3 First name/s

Surname

ID number

Date of birth Gender 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, please supply legal proof of adoption or foster care arrangement.

3. Choosing your dependant/s healthcare professional

Please complete this if you have selected the Standard Option

	Name	GP name	Practice number	Second GP name*	Practice number
Main applicant					
Spouse or partner					
Dependant 1**					
Dependant 2**					
Dependant 3**					

*If you live far away from where you work or you often need to work in different towns or provinces, your dependant/s may need a second GP. Please only choose a second GP if this applies to you.

**Please make sure that the dependant information you give above is the same as the dependant information in section 3 of this form.

4. Parents' details

Parent one surname

Parent one first name

Parent two surname

Parent two first name

5. 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?

3. Was the baby born with birth defects or abnormalities?

4. Is there any other information you feel we should be aware of?

6. Declaration

I, _____ (first name and surname), the main member, request that the newborn/s on this form be added to my health plan as a 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 **20**

Signature of main member

**The main applicant must sign and date any changes
Please do not sign an incomplete application form
I confirm the information is accurate and complete**

7. 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 (if applicable)

Name

Signature

Designation

Company stamp

Date