MEDSHIELD
medical scheme

NEW BORN REGISTRATION

Email: membership@medshield.co.za

This form needs to be completed for the registration of your newborn baby.
Please note that a newborn baby is defined as a biological child of the Principal Member or spouse born into the Scheme.
In order for your newborn baby to be registered from date of birth, you must register your newborn on the Scheme within 60 days from date of birth.

Please complete in black ink. All sections to be completed in full. Print clearly using capital letters. Only one character per block.
Leave one block between words. Mark with an X where necessary.

A COPY OF THE BIRTH CERTIFICATE FOR YOUR NEWBORN BABY MUST ACCOMPANY THIS FORM.

Membership Number:

SECTION A TO BE COMPLETED BY PRINCIPAL MEMBER

Member ID Number:

Member Name:

Member Surname:

SECTION B NEWBORN'S DETAILS

Dependant 1

Name of Dependant:

Surname: (If Different to Principal Member)

ID Number:

Relationship to Principal Member:

Gender: (Mark with an X) M F Adult Over 21: (Mark with an X) Y N

Please complete for statistical purposes. If you do not wish to disclose your dependant's race, please mark the relevant box with an X.

Race:	African	Caucasian/ White	Coloured	Indian	Asian	Other
I do not wish to disclose:						

Dependant 2

Name of Dependant:

Surname: (If Different to Principal Member)

ID Number:

Relationship to Principal Member:

Gender: (Mark with an X) M F Adult Over 21: (Mark with an X) Y N

Please complete for statistical purposes. If you do not wish to disclose your dependant's race, please mark the relevant box with an X.

Race:	African	Caucasian/ White	Coloured	Indian	Asian	Other
I do not wish to disclose:						

SECTION C

MediPhila: Each beneficiary MUST nominate only ONE (1) Family Practitioner from the MediPhila Family Practitioner Network to a maximum of two (2) Family Practitioners per family.

MediCurve: Each beneficiary must nominate only ONE (1) Family Practitioner from the MediCurve Family Practitioner (FP) Network.

MediValue Compact and MediPlus Compact: Each beneficiary MUST nominate ONE (1) Family Practitioner (FP) which MUST be from the Compact Family Practitioner (FP) Network.

MediValue Prime and MediPlus Prime: Voluntary - can nominate a FP which MUST be from the FP network to a MAXIMUM of two (2) FP's per beneficiary. *Where a FP was nominated from the FP Network & Day-to-Day benefit is depleted the member will qualify for an additional 2 visits per FAMILY from OAL.*

The registered networks per option are available on the website, please visit: **www.medshield.co.za**

Beneficiary	Beneficiary Name	Nominated Family Practitioner Name	Practice Number / Telephone
Principal Member		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 1		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 2		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 3		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 4		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 5		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 6		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 7		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY

SECTION D — EMPLOYER APPROVAL (Companies/Group members only)

Name of Employer:

Paypoint Code:

Employee Payroll No.:

Employment Date: D D M M Y Y Y Y

COMPANY STAMP

If no Company Stamp is available, please mark this block with an X.

We confirm that the applicant is employed by us and commenced employment on the above date and all fields of Section D have been completed:

Employer's Email Address:

Employer's Representative's Name:

Employer's Representative's Designation:

Date: D D M M Y Y Y Y

Employer's Representative's Signature: _____

SECTION E MEMBER DECLARATION

I, _____ (Principal Member's full name) the undersigned, declare that: I understand that Medshield will rely upon the facts set out herein for the accurate loading of details. I understand and accept that should any details contained herein prove to be incorrect, or should I fail to inform Medshield of any subsequent change to the details, Medshield will not be held responsible.

Principal Member Signature: _____ Date: D D M M Y Y Y Y