MATERNITY PROGRAM

Tel: +264 63 232 295 / +264 83 2999 000
E-mail copy of completed form to: care@prosperitynam.com

GEMHEALTH MEDICAL AID SCHEME

Section A - Member Details

Membership Number (Existing)					Existing Membership Number (Continuation members)						
Title		Initials			Full Names						
Surname											
Telephone Number	**H**	Code				**W**	Code				
Cellphone Number						Fax Number					
E-mail Address											
Marital Status	Single		Married		Divorced		Widowed		Common Law		
Date of Joining	**0**	**1**	M	M	Y	Y	Y	Y			

Section B - Medical Details *(To be completed by the Healthcare Professional.)*

Dependant Name														
Date of Birth	D	D	M	M	Y	Y	Y	Y	Age					
Healthcare Professional Name														
Normal Delivery					Caesarean (C-Section)									
Expecting Date	D	D	M	M	Y	Y	Y	Y						
Hospital Name														
*Other medical treatment to be received?	YES		NO		Attach doctors motivational documents				YES		NO			
*Please give details if yes?														
Pre-Authorisation Number														
Healthcare Professional Signature														
									Date	D	D	M	M	Y	Y	Y	Y

Section C - Employment Details *(For office use only)*

Private		Company						
CB Number								
Employment Date	D	D	M	M	Y	Y	Y	Y
Administration Notes								
Note: If joining date and employment date differ, please provide details hereto?								