MATERNITY PROGRAM

NAPOTEL
MEDICAL AID FUND

Tel: +264 61 201 2462 / +264 83 2999 000
E-mail copy of completed form to: care@prosperitynam.com

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?