

MATERNITY PROGRAM

Tel: +264 83 2999 000

Send e-mail to: care@prosperitynam.com



PROSPERITY HEALTH

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?												