

NEW BORN REGISTRATION AND TERMINATION OF DEPENDANT

Please

Termination of dependant membership

Registration of births (less than 60 days)

Please complete all the relevant sections in BLOCK LETTERS.

Please ensure that the following documentation accompanies your application.

- A copy of your new born birth certificate

Please note that if the benefit option selected is either MediValue or MediPhila, then this form needs to be accompanied by a completed MEM013 Family Practitioner nomination form.

MEMBERSHIP NUMBER

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

SECTION 1

TO BE COMPLETED BY PRINCIPAL MEMBER OF THE SCHEME

MEMBER SURNAME

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

MEMBER NAME

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

ID NUMBER

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

SECTION 2

DEPENDANT DETAILS

DEPENDANT SURNAME

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

DEPENDANT NAME

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

ID NUMBER

--	--	--	--	--	--	--	--	--	--	--	--	--	--

EFFECTIVE DATE

D	D	/	M	M	/	Y	Y	Y	Y
---	---	---	---	---	---	---	---	---	---

SECTION 3

EMPLOYER DETAILS

HUMAN RESOURCE CONTACT

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

TELEPHONE NO.

			-				-				
--	--	--	---	--	--	--	---	--	--	--	--

FAX NO.

			-				-				
--	--	--	---	--	--	--	---	--	--	--	--

E-MAIL ADDRESS

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

POSTAL ADDRESS

														CODE						

Company Stamp

EMPLOYER REPRESENTATIVE SIGNATURE: _____

SECTION 4

MEMBER DECLARATION

I, _____ (Principal member's full name) the undersigned, declare that:
a. 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
---	---	---	---	---	---	---	---

Completed form must be faxed to 010 597 4708 or submitted via e-mail to membership@medshield.co.za .