



# MATERNITY PROGRAMME REGISTRATION FORM

## SECTION 1

## MAIN MEMBER

Membership number:

ID number:

Population group:  African  Coloured  Indian  White  Asian

First name(s):   
(as per ID)

Surname:

Email:

Tel no:

## SECTION 2

## EXPECTANT MOTHER

### GENERAL INFORMATION

First names:   
(as per ID)

Surname:  Title:  Initials:

Residential/ postal address:   
  
 Code

Email:

Tel No:   Preferred contact time:  :

### MEDICAL INFORMATION

Weight:  ,  Height:  ,  Smoke:  Alcohol consumption:  Exercise:

Detail of any allergies:

Do you have any chronic medication condition?  Yes  No

If yes, what treatment are you receiving?

### CURRENT PREGNANCY

First day of menstrual cycle:  Expected date of delivery:

Are you experiencing any chronic medical conditions during this pregnancy?  Yes  No

If yes, what treatment are you receiving?

### PAST PREGNANCY/PREGNANCIES

Number of times pregnant:   Number of children you have:

Have you in the experienced:  Miscarriage  Stillbirth  Ectopic pregnancy

Were your child(ren) delivered by:  Vaginal Birth  Caesarean section birth

Did you experience any complication during and/or after the birth of your child(ren)?  Yes  No

Did you have any medical condition during your past pregnancy/pregnancies?  Yes  No

Did you child(ren) have any complications or medical condition after birth?  Yes  No

Did you breastfeed or bottled feed?  Breast  Bottle

## SECTION 3

## TREATING DOCTOR

Surname:  Initials:

Practice number:

Email:

Tel No:

Please Return This Form via Fax: 011 221 5118  
or email [sizwebaby@healthchoices.com](mailto:sizwebaby@healthchoices.com)



# MATERNITY PROGRAMME APPLICATION

## FUND DECLARATION

As Sizwe Medical Fund we are required by POPIA to explain how we obtain, use, disclose and otherwise process your information, which may include health and financial information (Personal Information). Sizwe Medical Fund and its administrator (Sechaba Medical Solutions (Pty) Ltd) will keep your information, including your personal information supplied to us in this application confidential. Acceptance of these terms and conditions is a requirement for activation and servicing of your medical scheme membership. You agree to us processing your personal information for the following purposes:

- (a) administration of your health care option;
- (b) provision of managed care services to you;
- (c) providing relevant information to a contracted third party;
- (d) to profile and analyse risk;
- (e) for research purposes;
- (f) to comply with legislation.

Please note that we will only share your information with a third party if you have already given your consent for the disclosure of this information to such third party or if a contractual relationship exists in terms of which we are obliged to provide your information to such third party. We may amend this notice from time to time, please check your website to inform yourself of any changes.

## BROKER DETAILS:

Broker:	<input type="text"/>
Full name(s):	<input type="text"/>
Tel:	<input type="text"/>
Email:	<input type="text"/>