SIZWE HOSMED
MEDICAL SCHEME
Your choice for quality care

086 010 3454
bambino@sizwehosmed.co.za
Waterfall Office Park,
1 Bekker Rd, Vorna Valley,
Midrand
1696

MATERNITY PROGRAMME APPLICATION

SECTION 1 MAIN MEMBER

Membership number:	
ID number	

Population group: African ☐ Coloured ☐ Indian ☐ White ☐ Asian ☐

(as per ID) First Name (s):	
Surname:	
Email:	
Tel no:	

SECTION 2 EXPECTANT MOTHER

GENERAL INFORMATION

(as per ID) First Name (s):					
Surname:		Title:		Initials:	
Residential/ postal address:					
				Code:	
Email:					
Tel No:		Preferred contact time:			

MEDICAL INFORMATION

Weight:	,	Height:	,	Smoke: ☐	Alcohol consumption: ☐	Exercise: ☐	
Details of any allergies:							

Do you have any chronic condition? No ☐

If yes, please provide details of condition and treatment	

CURRENT PREGNANCY

First day of menstrual cycle:		Expected date of delivery:	D D M M Y Y Y Y

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

If yes, please provide details of condition and treatment	

PAST PREGNANCY/PREGNANCIES

Number of times pregnant:		Number of children you have:

Have you previously experienced: Miscarriage ☐ Stillbirth ☐ Ectopic pregnancy ☐

Did you experience any complication during and/or after the birth of your child(ren)?	
Did you have any medical condition during your past pregnancy/pregnancies?	
Did your child(ren) have any complications or medical condition after birth?	

Did you breastfeed or bottled feed? Breast ☐ Bottle ☐

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SECTION 3 TREATING DOCTOR

Surname:		Initials:	
Practice number:			
Email:			
Tel No:			

SCHEME DECLARATION

As Sizwe Hosmed Medical Scheme we are strongly committed to protecting your personal data. We are required by POPIA to explain why and how we collect, use, and disclose your personal information, which may include health and financial information. Sizwe Hosmed Medical Scheme will keep your 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 give us consent to process 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 and;
f. To comply with legislation.

Please note that we will only share your information with a third party if you have granted us your consent for the disclosure of the 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 our website to inform yourself of any changes.

Member Signature: _____

Date: D D M M Y Y Y Y

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