Application for the registration of a newborn baby

Contact details
Tel: 0860 002 133 • PO Box 10436, Johannesburg, 2000 • www.sabmas.co.za

Who we are

SAB Medical Aid (referred to as 'the Scheme'), registration number 1209, is the medical scheme that you are applying to become a member of. This is a not-for-profit organisation, registered with the Council for Medical Schemes.

3Sixty Health (Pty) Ltd, registration number 1978/001109/07, is an accredited administration and managed care service provider responsible for administration of your membership on behalf of the Scheme.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. Provision is made in this form for you and your dependants to provide information relating to your race. This information is required by the Council for Medical Schemes for statistical purposes only. You are not compelled to provide this information.
3. Please email this completed and signed form with any supporting documents to application@sabmas.co.za or fax it to 010 593 2074.
4. Please attach a copy your newborn baby's unabridged birth certificate.

By signing this application, you confirm that you have read and understood the rules for membership and agree to them (available on the Scheme's website at www.sabmas.co.za).

If you have any questions, please let us know. Once we have assessed your application, we will let you know if your newborn has been accepted and what will happen next.

Please note:

You will have to pay increased contributions from the first day of the month following the month of birth and benefits will accumulate from the date of birth.

If your newborn baby is adopted or fostered, please complete the "Application to add dependants" form, irrespective of your newborn's age.

1. Principal member's details

Membership number | Applicant's employee number

ID Number | Gender M F

Member's surname

Member's first name/s
(as per identity document)

Race African Coloured Indian/Asian White Other

You are not compelled to provide this information. The scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Do not want to disclose

2. Newborn's details

2.1 First name/s

Surname

ID Number

Date of birth D D M M Y Y Y Y | Gender M F

Race African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐

You are not compelled to provide this information. The scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Do not want to disclose ☐

Is the newborn your biological child? Yes ☐ No ☐

2.2 First name/s

Surname

ID Number

Day of birth D D M M Y Y Y Y Gender M ☐ F ☐

Race African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐

You are not compelled to provide this information. The scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Do not want to disclose ☐

Is the newborn your biological child? Yes ☐ No ☐

2.3 First name(s)

Surname

ID Number

Date of birth D D M M Y Y Y Y Gender M ☐ F ☐

Race African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐

You are not compelled to provide this information. The scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Do not want to disclose ☐

Is the newborn your biological child? Yes ☐ No ☐

3. Please only select a GP if you have an Essential Plan

If you choose the Essential Plan

Please complete this if you have selected the Essential Plan. Essential members will need to nominate two chosen GPs. To make sure you are still able to get the treatment you need, you will be able see a doctor, who is not your chosen GP, three times a year. Thereafter, there will be a penalty co-payment for all non-nominated or out of area GP visits. This penalty will be applied in addition to the existing 20% surcharge on consultations.

	Name	GP name	Practice number	Second GP name*	Practice number
Main applicant					
Spouse or partner					
Dependant 1**					
Dependant 2**					
Dependant 3**					

** Please make sure that the dependant information you give above is the same as the dependant information in section 3 of this form.

4. Parents' details

Parent one first name

Parent one surname

Race African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐

You are not compelled to provide this information. The scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Do not want to disclose ☐

Parent two first name

Parent two surname

Race African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐

You are not compelled to provide this information. The scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Do not want to disclose ☐

5. Declaration

I, (first name and surname), the principal member,

request that the newborn/s on this form be added to my membership as a registered dependant/s. I also confirm that all the information given here is true to the best of my knowledge and belief.

Signed at (town or city) Date D D M M Y Y Y Y

Signature of principal member

The main applicant must sign and date any changes.
Please do not sign an incomplete application form.

6. Approval from employer

Employer name

Employer contact name

and surname

Payroll to verify the date the form was received D D M M Y Y Y Y

Signature

Designation Date D D M M Y Y Y Y

COMPANY STAMP