TFG MEDICAL AID SCHEME

Administered by Discovery Health

**Contact details**
Tel: 0860 123 077 • PO Box 652509, Benmore 2010 • www.tfgmedicalaidscheme.co.za

# Application for registration of newborn baby 2021

## For TFG office use

| | |
|---|---|
| Employee number | |
| Cost centre code | |
| Branch code | |

### Who we are

TFG Medical Aid Scheme (referred to as 'the Scheme'), registration number 1578, 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.

Discovery Health (Pty) Ltd (referred to as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). We take care of the administration of your membership for the Scheme.

### How to complete this form

Thank you for deciding to register your newborn baby on your TFG Medical Aid Scheme membership. This document is an application form to register your newborn baby on your TFG Medical Aid Scheme membership.

1. Please use one letter per block, complete in black ink and print clearly.
2. Please make sure the main applicant signs this application and dates any changes.
3. Please attach a copy of the birth certificate for your newborn baby.
4. Return to the Payroll Department, TFG Head Office, Parow.

**When you sign this application, you confirm that you have read and understood the terms and conditions for membership and agree to them.**

If you have any questions, please let us know. Once we have assessed your application, we will let you know what will happen next.

**Please note:**

For us to accept your newborn baby without any conditions, you must register your newborn baby within 90 days of his or her birth and cover must start from the date of birth. If you do not register your baby from the day he or she is born, you have to pay backdated contributions.

If you are applying after 90 days from birth of your newborn baby or you want the cover to start on any other day after the date of birth, we may apply certain conditions to your baby's membership with the Scheme. You will need to complete a different application called "Application to add a dependant to TFG Medical Aid Scheme".

## 1. Main member's details

| | |
|---|---|
| Membership number | |
| Employee number | |
| Member's name | |
| Member's surname | |

## 2. Newborn's details

| | |
|---|---|
| 2.1 First name/s | |
| Surname | |
| ID Number | |
| Date of birth | D D M M Y Y Y Y  Sex M F |

TFGARN001

The latest version of the application form is available on www.tfgmedicalaidscheme.co.za.
Alternatively members can phone 0860 123 077 and health professionals can phone 0860 44 55 66.

Is the newborn your biological child? Yes ☐ No ☐ or is the newborn adopted or fostered? Yes ☐ No ☐

If the newborn is adopted or fostered, please supply proof of adoption or foster care arrangement.

2.2 First name/s

Surname

ID Number

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

Is the newborn your biological child? Yes ☐ No ☐ or is the newborn adopted or fostered? Yes ☐ No ☐

If the newborn is adopted or fostered, please supply proof of adoption or foster care arrangement.

2.3 First name(s)

Surname

ID Number

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

Is the newborn your biological child? Yes ☐ No ☐ or is the newborn adopted or fostered? Yes ☐ No ☐

If the newborn is adopted or fostered, please supply proof of adoption or foster care arrangement.

## 3. Choosing your dependant/s healthcare professional

**Choosing your dependant/s healthcare professional**

If you are on TFG Health, you need to choose a GP from the KeyCare Network for your dependant/s. Please fill in the details of the GP you have chosen for your dependant/s.

*If you live far away from where you work or you often need to work in different towns or provinces, your dependant/s may need a second GP.

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

## 4. Parents' details

Mother's surname

Mother's first name

Father's surname

Father's first name

## 5. Birth details - Clone

1. Type of delivery? Normal vaginal delivery ☐ Caesarean section ☐ Vacuum delivery ☐ Forceps ☐

2. Did the baby sustain injuries or experience complications at birth?

3. Was the baby born with birth defects or abnormalities?

4. Is there any other information you feel we should be aware of?

## 6. Declaration

I,

(first name and surname), the main member, request that the newborn/s on this form be added to my health plan 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) on D D M M Y Y Y Y

Signature of main member

**The main applicant must sign and date any changes**
**Please do not sign an incomplete application form**
**I confirm the information is accurate and complete**