HERITAGE HEALTH

We care about your health

Heritage Square, 100 Robert Mugabe Avenue
Office 2, Ground Floor
Box 23091, Windhoek, Namibia

+264 61 230213 / 230226 +264 61 271287

admin@heritagehealth-namibia.com

www.heritagehealth-namibia.com

A. Maternity Benefit Registration

Membership Number

Principal Member Details Below

Surname

First Names

Personal Postal Address

Tel Code and Number

Fax Code and Number

Cell Phone Number

Email Address

Date of Birth D D M M Y Y Y Y

Gender Male Female

ID/Passport Number

B. Particulars of spouse requesting registration for maternity benefit

Full Names of Spouse

Tel Code and Number

Fax Code and Number

Cell Phone Number

Email Address

Date of Birth D D M M Y Y Y Y

I AUTHROISE THE MEDICAL AID FUND TO OBTAIN MORE CLINICAL INFORMATION ON MY/OUR BEHALF

……………………………………………………………… ………………………………………

SIGNATURE PRINCIPAL MEMBER/PATIENT DATE

C. Particulars of Attending Medical Practitioner

Information on this page to be provided by the doctor.

Name of Doctor

Name of Practice

Practice Number

Tel Code and Number

Fax Code and Number

Mobile Number

Email Address

D. General Information

How many times have you been pregnant?

How many children do you have?

Were your confinements premature, full term or late?

Were any of your babies born with congenital defects?

Did you have vaginal delivery or caesarean?

Did you experience any complications?

If you had a caesarean section, was it planned procedure or an emergency?

Are you currently being treated for any chronic condition?

What is the planned method of delivery?

Name of hospital for the delivery

Please note that you will need to apply for a pre authorisation number prior to delivery.

E. Authorisation details *(office use)*

Date received: ……………………………………

Date processed: …………………………………

Approved: …………………………………………

Declined and reason: ……

Inform patient: …………………………

Employee name: ……………………………………………… Signature: …………………………… Date: ……………………………