Medimed
Managing your healthcare security

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MATERNITY PROGRAMME APPLICATION

SECTION A: IMPORTANT INFORMATION

1. One application must be completed per beneficiary applying for enrolment per pregnancy.
2. Allow 5 working days for the processing of your application.
3. Please submit completed forms as incomplete information may delay registration.
4. Approval of enrolment is subject to the rules of the Scheme and Momentum TYB Clinical Protocols.
5. Please send completed forms to wellbeing@medimed.co.za or contact the Disease Risk Management team on 086 177 7660 with any queries.
6. Please note this form does not need to be completed by a doctor, members can complete the form.

SECTION B: BENEFICIARY DETAILS

Scheme | Option

Title | Initials | First Names | Surname

Medical Aid Number | Identity Number/ Passport Number | Date of Birth (Y Y Y Y M M D D)

Telephone Number (Home) | Cellphone Number

E-mail Address

Residential Address

Street Number / Street Name and Suburb

City and Province | Code

Preferred way of communication *(please tick one option):* Tel (H) ☐ Cellphone ☐ Email ☐

SECTION C: HISTORY

Current weight kg **Height** m **Hip/Waist ratio** **Smoker?** Y N Ave per day

Alcohol Y N Units/week **Allergies** Y N Specify

Exercise: Frequency times a week Type Intensity *(Tick):* Low ☐ Medium ☐ High ☐

Current blood pressure mmHg **Pulse** /m **Blood Glucose (HGT)** mmol/L

Chronic Conditions: Cardiovascular ☐ Endocrine ☐ Respiratory ☐ Psychiatric ☐ HIV ☐ Other ☐

Please specify **Chronic Authorisation** **IHC**

SECTION D: CURRENT PREGNANCY

Last Menstrual Period (Y Y Y Y M M D D) Expected Date of Delivery (Y Y Y Y M M D D)

Weeks Pregnant weeks Previous Pregnancies *(including current pregnancy)* Number of live births

Is this a multiple pregnancy? Y N If yes, Twins ☐ Triplets ☐ Fertility Treatments? Y N

Have you had any antenatal scans? Y N If yes, were any problems detected?

Are you currently suffering from any of the following pregnancy induced conditions?

Gestational Hypertension Pre-Eclampsia Gestational Diabetes Placenta Previa

Mode of delivery *(planned):* Normal Vaginal Birth Caesarian Section *If yes, please select indication*

Elective Caesarian Previous Caesar Multipe Births High Risk Pregnancy

SECTION E: PREVIOUS PREGNANCY

Have you ever had a multiple pregnancy? Y N If yes, Twins Triplets Fertility Treatments?

Have you previously had a miscarriage, stillbirth, ectopic pregnancy? Y N If yes, please provide details:

Have you previously had amniocentesis tests carried out? Y N If yes, please provide details:

Did you experience any of the following during previous pregnancies? Small for gestational age Preterm labour

Gestational Hypertension Pre-Eclampsia Gestational Diabetes Placenta Previa

SECTION F: PREVIOUS DELIVERIES

Previous deliveries? Vaginal birth Y N Number Caesarian Y N Number

Did you experience any of the following during a vaginal birth? Induced labour Vacuum extraction

Forceps Complications *Please specify*

Please provide reasons for the caesarian delivery: Elective caesarian Emergency caesarian Previous Caesar

High Risk Pregnancy Other *Please specify*

Did you experience any of the following complications after the birth of your children? Placental retention

Severe bleeding Post partum infection Breast feeding problems Post natal depression

SECTION G: PREVIOUS NEONATAL COMPLICATIONS

Did your newborn babies experience any health problems Y N *If yes, please specify* Preterm Gestation

Breathing problems Neo-natal jaundice Bleeding under scalp Feeding problems

Other *Please specify*

SECTION H: MEDICAL PRACTIONER DETAILS

General Practioner: Surname Initials Prac Number

Telephone Number E-mail

Gynae/Obstetrician: Surname Initials Prac Number

Telephone Number E-mail

Midwife: Surname Initials Prac Number

Telephone Number E-mail

Enrolment form completed by: Name Designation

Medical Aid Number:

SECTION I: DECLARATION

By signing below, I hereby acknowledge and agree to the following:

- My (or my minor dependant's) health care provider may provide clinical information as requested by Medimed medical scheme.
- Maternity benefits as described in the benefit guide are subject to registration on the Maternity programme and subject to scheme rules.
- I accept that I have a responsibility to my own health and that of my unborn child, irrespective of the funding decisions made by Medimed medical scheme.
- All treatment decisions remain the responsibility of the beneficiary's health care provider and should not be affected by the scheme rules, clinical criteria or protocols.
- All information concerning this application will remain confidential at all times, Medimed and the contracted Administrator will keep your personal information confidential and will adhere to the Protection of Personal Information Act, 2013 when processing your personal information. Your personal information will be processed for the purpose of the Medical Schemes Act 131 of 1998.

Print Name and Surname

Date: Y Y Y Y M M D D

Expectant mother's signature *(or guardian)*

Relationship (if guardian)