GOLDEN ARROW
EMPLOYEES' MEDICAL BENEFIT FUND

MATERNITY PROGRAMME APPLICATION

1. 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 its Administrators' Clinical Protocols.
5. Please send completed forms to wellbeing@goldenarrowmed.co.za or contact the Disease Risk Management team on 0860104122 with any queries.

2. BENEFICIARY DETAILS

Scheme: Option:

Full Name: Medical Aid Number:

ID/passport Number: Date of Birth:

Tel Number: Cell Number:

Email Address:

Residential Address:

Preferred form of communication *(please tick one option):* Tel ☐ Cell ☐ Email ☐

3. HISTORY

Current weight: kg Height: m

Hip/Waist ratio: Smoker? Y ☐ N ☐ Avg per day:

Alcohol: Units/week Allergies: Y ☐ N ☐ Specify:

Current blood pressure: mmHg Pulse: /m

Blood Glucose (HGT): mmol/L

Exercise: Frequency: times a week Type:

Intensity *(Tick):* Low ☐ Medium ☐ High ☐

Chronic Conditions:

Cardiovascular ☐ Endocrine ☐ Respiratory ☐ Psychiatric ☐ HIV ☐

Other ☐ Please specify:

Chronic Authorisation: IHC

Tel 0860 104 122 Fax 021 480 2734
PO Box 15729, Vlaeberg 8018
Parc du Cap, 7 Mispel Road, Bellville 7530

Medical Aid Number:

4. CURRENT PREGNANCY

Last Menstrual Period: Expected Date of Delivery:

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* *Multiple Births* *High Risk Pregnancy*

5. PREVIOUS PREGNANCY

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

Fertility Treatments? Y N

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

6. 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

Tel 0860 104 122 Fax 021 480 2734
PO Box 15729, Vlaeberg 8018
Parc du Cap, 7 Mispel Road, Bellville 7530

Medical Aid Number:

7. 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*

8. MEDICAL PRACTITIONER DETAILS

General Practitioner:

Surname: Initials: Practice No.: Tel:

Email:

Gynae/Obstetrician:

Surname: Initials: Practice No.: Tel:

Email:

Midwife:

Surname: Initials: Practice No.: Tel:

Email:

Enrolment form completed by:

Name: Designation:

9. DECLARATION

By signing below, I hereby give permission for, acknowledge and/or agree to the following:

- My (or my minor dependant's) health care provider may provide clinical information as requested by the Scheme and its Administrators.
- 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 the Scheme and its Administrators
- 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, The Scheme and its Administrators 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.

Patient Name and Surname:

Date:

Expectant mother's signature *(or guardian)*:

Relationship (if guardian):

12/2025

Tel 0860 104 122 Fax 021 480 2734
PO Box 15729, Vlaeberg 8018
Parc du Cap, 7 Mispel Road, Bellville 7530