GOLDEN ARROW
EMPLOYEES' MEDICAL BENEFIT FUND

ENROLMENT FORM
MATERNITY PROGRAMME

Please note that this form must be completed by the expectant mother.

PLEASE USE BLOCK LETTERS FOR ALL SECTIONS

1. MEMBER AND PATIENT INFORMATION

MAIN MEMBER DETAILS

Membership number

Benefit option ☐ Primary Option ☐ Standard Option ☐ Advanced Option

Title | Initials | ID number

Full name and surname

Email address

DETAILS OF EXPECTANT MOTHER

Dependant code

Title | Initials | ID number

Full name and surname

Contact numbers | Home | Work

Cell phone

Kindly indicate your preferred day and time for contact (Mon - Fri 9:00 - 16:00)

Postal address

Postal code

Email address

Preferred method of contact

Telephonic ☐ Home ☐ Work ☐ Cell phone

Written ☐ Post ☐ Email

PATIENT CONSENT

I understand that Golden Arrow Employees' Medical Benefit Fund and Momentum Health Solutions, the Administrator, will maintain the confidentiality of my personal information and comply with the Protection of Personal Information Act 4 of 2013 (POPIA) and all existing data protection legislation, when collecting, processing and storing my personal information for the purposes of registration on the Maternity Programme.

I understand that:

- Funding for this benefit is subject to meeting benefit entry criteria requirements as determined by the Fund.
- The benefit provides cover for therapy scientifically proven for my condition, which means that not all medication for the condition will automatically be covered.
- By registering for the benefit, I agree that my condition may be subject to disease management interventions and periodic review and that this may include access to my medical records.
- Funding will only be effective once the Fund receives an application form that is completed in full.

Membership number | **Doctor's practice number**

1. MEMBER AND PATIENT INFORMATION (CONTINUED)

PATIENT CONSENT (CONTINUED)

- Payment to the healthcare professional for the completion of this form, on submission of a claim, will be subject to the Fund rules and where the member is a valid and active member at the service date of the claim.
- I agree to my information being used to develop registries. This means that you give permission for us to collect and record information about your condition and treatment. This data will be analysed, evaluated and used to measure clinical outcomes and to make informed funding decisions.
- To ensure that we pay your claims from the correct benefit, any claims from your healthcare providers must include the relevant ICD-10 diagnosis code(s). Please ask your doctor to also include the relevant ICD-10 diagnosis code(s) on the referral form for any pathology and/or radiology tests. This will enable the pathologists and radiologists to also include the relevant ICD-10 diagnosis code(s) on the claims they submit, thus further ensuring that we pay your claims from the correct benefit.

CONSENT FOR PROCESSING MY PERSONAL INFORMATION

1. I hereby acknowledge that Golden Arrow Employees' Medical Benefit Fund has appointed Momentum Health Solutions (Pty) Ltd as the administrator of the programme and that any prescribed medical treatment shall be the sole responsibility of my medical practitioner. I understand that the information provided on this form shall be treated as confidential and will not be used or disclosed except for the purpose for which it has been obtained.
2. I hereby give my consent to the Fund, Momentum Health Solutions and its employees to obtain my, or any of my dependants', special personal information (including general, personal, medical or clinical), whether it relates to the past or future (e.g. health and biometric) from any of my healthcare providers (e.g. pharmacist, pathologist, radiologist, treating doctor and/or specialist) to assess my medical risk, enrol me on the programme and to use such information to my benefit and to undertake managed care interventions related to my chronic condition(s).
3. I understand that this information will be used for the purposes of applying for and assessing my funding request for chronic benefits.
4. I give permission for my healthcare provider to provide the Fund and the administrator with my diagnosis and other relevant clinical information required to review and process my application.
5. I consent to the Fund and the administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical) to my healthcare provider, to administer the chronic benefits.
6. Whilst Momentum Health Solutions undertakes to take all reasonable precautions to uphold the confidentiality of information disclosed to it, I am aware that the Fund and my healthcare provider (where necessary) shall also gain access to the same information. I shall therefore not hold Momentum Health Solutions and its employees or the Fund and its trustees, liable for any claims by me or my dependants arising from any unauthorised disclosure of my special personal information to other parties.
7. I understand and agree that special personal information relevant to my current state of health may be disclosed to third parties for the purpose of scientific, epidemiological and/or financial analysis without disclosure of my identity.

I hereby certify that the information provided in this application is true and correct.

Member/patient signature
(or signature of parent/ guardian if patient is under the age of 18)

Date
DD/MM/YYYY

2. MEDICAL PRACTITIONERS' INFORMATION

DOCTOR DETAILS

Practice number

Initials

Speciality

Surname

Contact numbers

Work

Fax

Cell phone

Postal address

Postal code

Email address

Membership number

Doctor's practice number

2. MEDICAL PRACTITIONERS' INFORMATION (CONTINUED)

GYNAECOLOGIST/MIDWIFE DETAILS

Practice number | Contact number

Speciality

Full name and surname

Email address

3. MEDICAL INFORMATION AND HISTORY

GENERAL HEALTH INFORMATION

Weight ____ kg Height ____ cm

Smoker ☐ Never ☐ Ex-smoker ☐ <10 per day ☐ >10 per day

Exercise ☐ Never ☐ <1 hour per week ☐ 1-3 hours per week ☐ >3 hours per week

Allergies ☐ Penicillin ☐ Aspirin ☐ Sulphonamides

Other

Are you currently being treated for any medical conditions, e.g. asthma, diabetes, HIV/AIDS, tuberculosis or depression? If yes, please list the condition(s): ☐ Yes ☐ No

If you think you are at risk of being HIV positive, or have been diagnosed as a person living with HIV/AIDS, please register on the LifeSense HIV Programme on 0860 50 60 80 (all calls are confidential).

Do you consume alcohol? ☐ Yes ☐ No

If yes, how often? Less than two glasses per day ☐ Yes ☐ No

More than two glasses per day ☐ Yes ☐ No

DETAILS OF CURRENT PREGNANCY

First day of last menstrual period (DD/MM/YYYY)

Expected delivery date (DD/MM/YYYY)

DETAILS OF PREVIOUS PREGNANCIES

Number of pregnancies (excluding this one)

How many children do you have?

Twins ☐ Yes ☐ No

Triplets ☐ Yes ☐ No

Have you previously experienced a miscarriage/stillbirth/an ectopic pregnancy? If yes, please provide details: ☐ Yes ☐ No

Membership number **Doctor's practice number**

3. MEDICAL INFORMATION AND HISTORY (CONTINUED)

DETAILS OF PREVIOUS PREGNANCIES (CONTINUED)

Were any of your babies born with health problems, e.g. premature, spinal cord defects, congenital defects or late stillbirth? If yes, please provide details (especially if the baby underwent surgery): ☐ Yes ☐ No

Have you previously had amniocentesis tests carried out? If yes, please specify reasons: ☐ Yes ☐ No

Were any of your babies born prematurely? ☐ Yes ☐ No

Did you carry two weeks over term? ☐ Yes ☐ No

How were your children delivered?

- ☐ Vaginal birth
- ☐ Caesarean birth

Did you experience any of the following during a vaginal birth?

- ☐ Complications
- ☐ Induced labour
- ☐ Vacuum extraction (delivery of baby with suction device)
- ☐ Forceps-assisted birth (delivery of baby with forceps)

Reason for caesarean birth (if applicable):

- ☐ Elective (by choice)
- ☐ Other (please specify)

Did you experience any of the following during pregnancy?

- ☐ High blood pressure
- ☐ Diabetes
- ☐ Pre-eclampsia (high blood pressure with protein in the urine)

Any other problems experienced (please specify):

Please indicate if any of the following complications were experienced after the birth of your child:

- ☐ Breast problems
- ☐ Placenta retention
- ☐ Post-natal depression
- ☐ Severe bleeding
- ☐ Wound infection

Condition of baby/ies after delivery:

- ☐ Bleeding under scalp
- ☐ Breathing problems
- ☐ Neonatal jaundice (yellowing of newborn's skin)
- ☐ Paralysis (unable to move one or more limbs)
- ☐ Other (please specify)

Did you breastfeed your baby/ies? ☐ Yes ☐ No If yes, for how long (weeks/months)?

Membership number

Doctor's practice number