



DEPENDANT DISABILITY INFORMATION

Main Member

Membership number:

Dependant number:

Title:

Name(s):

Surname:

Date of birth: ID number:

Passport number, if no ID:

Nature of Disability (Please tick the applicable box)

Temporary: Permanent:

Limitation (Please tick the applicable box)

Mild: Moderate: Severe:

Start date: End date:

Treating Provider Details

Practice number: Name(s):

Initial(s): Surname:

Cellphone: Telephone:

Practitioner email

Should this space be insufficient, please attach a separate sheet.

Dependant One

Membership number:

Dependant number:

Title:

Name(s):

Surname:

Date of birth: ID number:

Passport number, if no ID:

Nature of Disability (Please tick the applicable box)

Temporary: Permanent:

Limitation (Please tick the applicable box)

Mild: Moderate: Severe:

Start date: End date:

Treating Provider Details

Practice number: Name(s):

Initial(s): Surname:

Cellphone: Telephone:

Practitioner email

Should this space be insufficient, please attach a separate sheet.

