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OUR INVESTMENT OUR HEALTH OUR FUTURE

DEPENDANT DISABILITY INFORMATION

Main Member

Membership number:
Dependant number:
Title:
Name(s):
Surname:
Date of birth: D D M M Y Y Y Y ID number:
Passport number, if no ID:

Nature of Disability* *(Please tick the applicable box)*
** This Section is Compulsory.*

Disability Type:

Hearing Disability: Intellectual Disability: Mental Disability:
Physical Disability: Speech Disability: Vision Disability:

Temporary: Permanent:

Limitation *(Please tick the applicable box)*

Mild: Moderate: Severe:
Start date: D D M M Y Y Y Y End date: D D M M Y Y Y Y

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: D D M M Y Y Y Y ID number:
Passport number, if no ID:

Nature of Disability* *(Please tick the applicable box)*
** This Section is Compulsory.*

Disability Type:

Hearing Disability: Intellectual Disability: Mental Disability:
Physical Disability: Speech Disability: Vision Disability:

Temporary: Permanent:

Limitation *(Please tick the applicable box)*

Mild: Moderate: Severe:
Start date: D D M M Y Y Y Y End date: D D M M Y Y Y Y

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Dependant One *(Continued)*

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 Two

Membership number:

Dependant number:

Title:

Name(s):

Surname:

Date of birth: D D M M Y Y Y Y ID number:

Passport number, if no ID:

Nature of Disability* *(Please tick the applicable box)*

** This Section is Compulsory.*

Disability Type:

Hearing Disability: Intellectual Disability: Mental Disability:

Physical Disability: Speech Disability: Vision Disability:

Temporary: Permanent:

Limitation *(Please tick the applicable box)*

Mild: Moderate: Severe:

Start date: D D M M Y Y Y Y End date: D D M M Y Y Y Y

Treating Provider Details

Practice number: Name(s):

Initial(s): Surname:

Cellphone: Telephone:

Practitioner email

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

MAIN MEMBER

I hereby declare that the information supplied is true and correct.

Title:

Name(s):

Surname:

ID number:

Membership number: