

Application for the registration of a newborn baby 2026



Contact details
Tel: 0860 002 133 • www.sabmas.co.za

Who we are

SAB Medical Aid (referred to as 'the Scheme'), registration number 1209, is the medical scheme that you are a member of. This is a not-for-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, (referred to as 'the Administrator') is a separate company and an authorised financial services provider and is responsible for the administration of your membership on behalf of the Scheme.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly. Alternatively, complete it digitally.
2. Please email this completed and signed form with any supporting documents to application@sabmas.co.za.
3. Please attach a copy your newborn baby's unabridged birth certificate.

You will have to pay increased contributions from the first day of the month following the month of birth and benefits will accumulate from the date of birth.

If your newborn baby is adopted or fostered, please complete the "Application to add dependants" form, irrespective of your newborn's age.

1. Principal member's details

Membership number	
ID or passport number	
Member's surname	
Member's name	

2. Newborn's details

2.1. Surname	
First name(s)	
ID or passport number	
Gender	M ☐ F ☐
Date of birth	
Is the newborn your biological child?	Yes ☐ No ☐
2.2. Surname	
First name(s)	
ID or passport number	
Gender	M ☐ F ☐
Date of birth	
Is the newborn your biological child?	Yes ☐ No ☐
2.3. Surname	
First name(s)	
ID or passport number	
Gender	M ☐ F ☐
Date of birth	
Is the newborn your biological child?	Yes ☐ No ☐

3. Selecting your GP (Essential Option only)

Please complete this if you have selected the Essential Option. Members on the Essential Option will need to nominate two chosen GPs. To make sure you are still able to get the treatment you need, you will be able to see a doctor, who is not your chosen GP, three times a year. Thereafter, the fourth consultation onwards funds at sixty percent of the lower of claimed or negotiated rate.

	Name	Primary GP name	Practice number	Secondary GP name	Practice number
Dependant 1**					
Dependant 2**					
Dependant 3**					

** Please make sure that the dependant information you give above is the same as the dependant information in section 2 of this form

4. Parents' details

Mother's surname	
Mother's first name	
Father's surname	
Father's first name	

5. Declaration

I, (first name and surname), the principal member,
request that the newborn/s on this form be added to my membership as a registered dependant/s. I also confirm that all the information given here is true to the best of my knowledge and belief.

Signed at (town or city)

Signature of principal member

Date

D	D	M	M	Y	Y	Y	Y
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The principal member must sign and date any changes.
Please do not sign an incomplete application form.

6. Approval from employer

Employer name									
Employer contact name									
Employer contact surname									
Date the form was received by the employer	<table><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		
Signature									
Designation									
Date <table><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>		D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		
COMPANY STAMP									