

## Eligible Member Details

|                          |                                |                                |                                   |                                 |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--------------------------|--------------------------------|--------------------------------|-----------------------------------|---------------------------------|--------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Surname:                 |                                |                                |                                   |                                 |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Full Names:              |                                |                                |                                   |                                 |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ID Number:               |                                |                                |                                   |                                 |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Title:                   |                                |                                |                                   |                                 |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Employer:                |                                |                                |                                   |                                 |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Employer Levy Code:      |                                |                                |                                   |                                 |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Employer Contact Person: |                                |                                |                                   |                                 |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Employer Contact Number: |                                |                                |                                   |                                 |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Employer Postal Address: |                                |                                |                                   |                                 |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Cell:                    |                                | Work:                          |                                   | Home:                           |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Alternative Number:      |                                |                                |                                   |                                 |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Email Address:           |                                |                                |                                   |                                 |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Home Language:           |                                |                                |                                   |                                 |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Ethnic Group:            | White <input type="checkbox"/> | Black <input type="checkbox"/> | Coloured <input type="checkbox"/> | Indian <input type="checkbox"/> | Other <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

## Dependant Details

|                                     |                                |                                |                                   |                                 |                                |  |  |  |  |  |  |                                 |                                   |   |                                |  |  |  |  |  |
|-------------------------------------|--------------------------------|--------------------------------|-----------------------------------|---------------------------------|--------------------------------|--|--|--|--|--|--|---------------------------------|-----------------------------------|---|--------------------------------|--|--|--|--|--|
| Dependant 1. Full Name and Surname: |                                |                                |                                   |                                 |                                |  |  |  |  |  |  |                                 | Relation:                         | Spouse <input type="checkbox"/>           | Child <input type="checkbox"/> |  |  |  |  |  |
| Ethnic Group:                       | White <input type="checkbox"/> | Black <input type="checkbox"/> | Coloured <input type="checkbox"/> | Indian <input type="checkbox"/> | Other <input type="checkbox"/> |  |  |  |  |  |  | Adding <input type="checkbox"/> | Removing <input type="checkbox"/> |   |                                |  |  |  |  |  |
| ID Number:                          |                                |                                |                                   |                                 |                                |  |  |  |  |  |  |                                 |                                   |   |                                |  |  |  |  |  |
| Dependant 2. Full Name and Surname: |                                |                                |                                   |                                 |                                |  |  |  |  |  |  |                                 | Relation:                         | Spouse <input type="checkbox"/>           | Child <input type="checkbox"/> |  |  |  |  |  |
| Ethnic Group:                       | White <input type="checkbox"/> | Black <input type="checkbox"/> | Coloured <input type="checkbox"/> | Indian <input type="checkbox"/> | Other <input type="checkbox"/> |  |  |  |  |  |  | Adding <input type="checkbox"/> | Removing <input type="checkbox"/> |   |                                |  |  |  |  |  |
| ID Number:                          |                                |                                |                                   |                                 |                                |  |  |  |  |  |  |                                 |                                   |   |                                |  |  |  |  |  |
| Dependant 3. Full Name and Surname: |                                |                                |                                   |                                 |                                |  |  |  |  |  |  |                                 | Relation:                         | Child <input checked="" type="checkbox"/> |                                |  |  |  |  |  |
| Ethnic Group:                       | White <input type="checkbox"/> | Black <input type="checkbox"/> | Coloured <input type="checkbox"/> | Indian <input type="checkbox"/> | Other <input type="checkbox"/> |  |  |  |  |  |  | Adding <input type="checkbox"/> | Removing <input type="checkbox"/> |   |                                |  |  |  |  |  |
| ID Number:                          |                                |                                |                                   |                                 |                                |  |  |  |  |  |  |                                 |                                   |   |                                |  |  |  |  |  |
| Dependant 4. Full Name and Surname: |                                |                                |                                   |                                 |                                |  |  |  |  |  |  |                                 | Relation:                         | Child <input checked="" type="checkbox"/> |                                |  |  |  |  |  |
| Ethnic Group:                       | White <input type="checkbox"/> | Black <input type="checkbox"/> | Coloured <input type="checkbox"/> | Indian <input type="checkbox"/> | Other <input type="checkbox"/> |  |  |  |  |  |  | Adding <input type="checkbox"/> | Removing <input type="checkbox"/> |   |                                |  |  |  |  |  |
| ID Number:                          |                                |                                |                                   |                                 |                                |  |  |  |  |  |  |                                 |                                   |   |                                |  |  |  |  |  |
| Dependant 5. Full Name and Surname: |                                |                                |                                   |                                 |                                |  |  |  |  |  |  |                                 | Relation:                         | Child <input checked="" type="checkbox"/> |                                |  |  |  |  |  |
| Ethnic Group:                       | White <input type="checkbox"/> | Black <input type="checkbox"/> | Coloured <input type="checkbox"/> | Indian <input type="checkbox"/> | Other <input type="checkbox"/> |  |  |  |  |  |  | Adding <input type="checkbox"/> | Removing <input type="checkbox"/> |   |                                |  |  |  |  |  |
| ID Number:                          |                                |                                |                                   |                                 |                                |  |  |  |  |  |  |                                 |                                   |   |                                |  |  |  |  |  |

## How to Return this Form

Please attach a certified copy of the birth certificate and/or identity document. Additional documents may be required and will be confirmed with the Eligible Member.

The completed form can be:



E-mailed to: [info@nbcflihealth.co.za](mailto:info@nbcflihealth.co.za)

OR



Faxed to: 086 764 6091

|                               |  |       |
|-------------------------------|--|-------|
| Signature of Eligible Member: |  | Date: |
|                               |  |       |

**FOR ANY QUERIES PLEASE CONTACT  0861 00 11 31**