

De Beers Pension Fund and Benefit Society

M2.1a: Dependant's Medical History

To be completed when adding a dependant to the Benefit Society unless dependant less than 3 months old.

Must accompany M2.1, M2.2 & M2.3

Note: A separate form should be used for each dependant registered.

IMPORTANT: THIS FORM MUST BE PERSONALLY COMPLETED AND SIGNED BY THE MEMBER. IF ANY FALSE OR INCORRECT INFORMATION IS SUPPLIED HEREIN AND DETECTED AT A LATER STAGE, IT MAY RESULT IN BENEFITS ALREADY PAID BEING REVERSED AND CHARGED, IN FULL, TO THE MEMBER AND IT MAY ALSO RESULT IN THE MEMBER BEING SUSPENDED FROM THE BENEFIT SOCIETY.

SECTION A – MEMBER'S DETAILS			
SURNAME			
FIRST NAMES			
ID NUMBER		OPERATION	
POLICY NUMBER			

SECTION B – DEPENDANT TO BE REGISTERED			
SURNAME			
FIRST NAMES			
ID NUMBER		DATE OF BIRTH	

SECTION C – MEDICAL HISTORY OF DEPENDANT							
HAS THE DEPENDANT EVER SUFFERED FROM A DEFECT OR DISEASE RELATED TO ANY OF THE FOLLOWING? PLEASE TICK YES OR NO.							
		YES	NO			YES	NO
1	SKIN			18	CANCER		
2	EYE			19	DIABETES		
3	EAR			20	EPILEPSY/FITS		
4	NOSE			21	ULCERS		
5	THROAT			22	HERNIA		
6	SKELETON			23	KIDNEY/BLADDER		
7	HEART			24	RHEUMATIC FEVER		
8	CHEST			25	RHEUMATISM		
9	RESPIRATORY			26	SILICOSIS		
10	DIGESTIVE			27	STOMACH		
11	URINARY			28	TUBERCULOSIS		
12	GENITAL ORGANS			29	BROKEN BONES		
13	NERVOUS SYSTEM			30	BACK		
14	MENTAL			31	DRUG		
15	BLOOD			32	ALCOHOL		
16	AIDS			33	PREGNANCY		
17	ARTHRITIS			34	OTHER		

PROVIDE THE FOLLOWING INFORMATION FOR ANY DEFECT/DISEASES INDICATED ABOVE			
DEFECT/DISEASE		YEAR ORIGINATED	
DETAILS			
DEFECT/DISEASE		YEAR ORIGINATED	
DETAILS			
DEFECT/DISEASE		YEAR ORIGINATED	
DETAILS			
DEFECT/DISEASE		YEAR ORIGINATED	
DETAILS			

EMPLOYEE SIGNATURE		
I	Print name here	DECLARE THAT THE ABOVE INFORMATION IS TRUE AND CORRECT.
EMPLOYEE SIGNATURE		DATE