De Beers Benefit Society

M2.1A – Beneficiary's Medical History

To be completed by all new members and when a new dependant is added to the Benefit Society, unless the dependant is less than 3 months old (form not required).
Note: A separate form should be used for each beneficiary registered.

SECTION A – MEMBER'S DETAILS			
SURNAME			
FIRST NAMES			
ID NUMBER		DATE OF BIRTH	Y Y Y Y M M D D
PASSPORT NUMBER IF APPLICABLE		COUNTRY OF ISSUE	
MEMBER NUMBER (If not a new application)			

SECTION B – DEPENDANT TO BE REGISTERED			
SURNAME			
FIRST NAMES			
ID NUMBER		DATE OF BIRTH	Y Y Y Y M M D D
PASSPORT NUMBER IF APPLICABLE		COUNTRY OF ISSUE	

SECTION C – MEDICAL HISTORY OF DEPENDANT

HAVE ANY OF YOUR PROPOSED BENEFICIARY(-IES) RECEIVED ANY MEDICAL ADVICE, DIAGNOSIS, CARE OR WAS RECOMMENDED FOR TREATMENT IN THE LAST 12 MONTHS? PLEASE CLEARLY SPECIFY DIAGNOSED CONDITION IN THE RELEVANT TABLES.	INDICATE WITH AN "X" (COMPULSORY)	DATE DIAGNOSED	LAST TREATMENT DATE	LEVEL/STAGE OF ILLNESS, CONDITION, NATURE OF TREATMENT, MEDICINE, DOSAGE AND HOSPITALISATION
1. Skin conditions e.g. allergies, eczema, psoriasis, acne	Yes ☐ No ☐	Y Y Y Y M M D D	Y Y Y Y M M D D	
2. Skeleton, joint or muscle problems e.g. arthritis, back problems, rheumatism, rheumatic fever	Yes ☐ No ☐	Y Y Y Y M M D D	Y Y Y Y M M D D	
3. Sensory organ problems e.g. sight, hearing, speech	Yes ☐ No ☐	Y Y Y Y M M D D	Y Y Y Y M M D D	
4. Respiratory e.g. asthma, COPD, emphysema, silicosis	Yes ☐ No ☐	Y Y Y Y M M D D	Y Y Y Y M M D D	
5. Cardio-vascular system e.g. hypertension, high cholesterol, heart failure, thrombosis	Yes ☐ No ☐	Y Y Y Y M M D D	Y Y Y Y M M D D	
6. Digestive system e.g. hernia, ulcers, gallstones	Yes ☐ No ☐	Y Y Y Y M M D D	Y Y Y Y M M D D	
7. Urinary system e.g. kidney or bladder problems (infections or incontinence)	Yes ☐ No ☐	Y Y Y Y M M D D	Y Y Y Y M M D D	
8. Metabolic diseases e.g. diabetes, porphyria, thyroid problems	Yes ☐ No ☐	Y Y Y Y M M D D	Y Y Y Y M M D D	
9. Mental disorders e.g. depression, anxiety, sleeping disorders	Yes ☐ No ☐	Y Y Y Y M M D D	Y Y Y Y M M D D	
10. Brain and nervous system e.g. epilepsy, fits, stroke, Parkinson's disease, headaches	Yes ☐ No ☐	Y Y Y Y M M D D	Y Y Y Y M M D D	
11. Substance abuse e.g. alcohol, drugs	Yes ☐ No ☐	Y Y Y Y M M D D	Y Y Y Y M M D D	

84 Du Toitspan Road, Kimberley, 8301
P. O. Box 1922, Kimberley, 8300
Tel: 053-807-3111 Fax: 053-807-3499
Email – registrations@dbbs.co.za

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

SECTION C – MEDICAL HISTORY OF DEPENDANT (Continued)																			
HAVE ANY OF YOUR PROPOSED BENEFICIARY(-IES) RECEIVED ANY MEDICAL ADVICE, DIAGNOSIS, CARE OR WAS RECOMMENDED FOR TREATMENT IN THE LAST 12 MONTHS? PLEASE CLEARLY SPECIFY DIAGNOSED CONDITION IN RELEVANT TABLES.	INDICATE WITHAN "X" (COMPULSORY)	DATE DIAGNOSED								LAST TREATMENT DATE								LEVEL/STAGE OF ILLNESS, CONDITION, NATURE OF TREATMENT, MEDICINE, DOSAGE AND HOSPITALISATION
12. Cancer, growth or tumors	Yes ☐ No ☐	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
13. Ear, nose and throat e.g. grommets, nasal surgery, tonsils	Yes ☐ No ☐	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
14. Contagious diseases e.g. HIV / AIDS, tuberculosis	Yes ☐ No ☐	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
15. Pregnancy (Suspected or confirmed)	Yes ☐ No ☐	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
16. Genital organs or reproductive problems e.g. prostate, testes problems, infertility, menstrual problems, endometriosis, hormone replacement therapy	Yes ☐ No ☐	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
17. Blood e.g. anemia, bleeding disorders, blood clots	Yes ☐ No ☐	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
18. Any other medical condition, operation or symptoms experienced not mentioned above e.g. broken bones	Yes ☐ No ☐	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	

MEMBER SIGNATURE			
I	**Print name here**	DECLARE THAT THE ABOVE INFORMATION IS TRUE AND CORRECT	
SIGNATURE		DATE	

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