

## OPTION SELECTION FORM

**NB: ONLY COMPLETE THIS FORM IF YOU WANT TO CHANGE FROM YOUR CURRENT OPTION. PLEASE SUBMIT TO YOUR EMPLOYER IMMEDIATELY TO ENSURE THAT THE FORM REACHES MEDIMED BY 30<sup>th</sup> NOVEMBER 2018.**

**SECTION A: TO BE COMPLETED BY MEMBER**

I, ..... (name of member)

Membership No. 

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wish to change to the following option (please tick appropriate box):

MEDIMED OPTION FOR 2019	
Alpha	
Medisave Max	
Medisave Standard	
Medisave Essential (Complete Section C on 2 <sup>nd</sup> page)	

**DECLARATION**

1. I hereby acknowledge that I am familiar with the conditions and benefits of the option selected, notwithstanding representation by another party.
2. I understand that I must give written notice by 30 November 2018 of my intent to transfer to a new benefit option, which becomes effective 1 January 2019. I also accept that I can only change options once a year and will remain on this option until 31 December 2019.

Member's Signature ..... Date .....

**PLEASE NOTE:**

1. You are allowed to move from one option to another, once a year – i.e. on 1 January, each year.
2. If you choose a benefit option other than your existing option, you will be issued with a revised membership card. Therefore, prompt response in returning the option selection will be greatly appreciated.

**SECTION B: TO BE COMPLETED BY EMPLOYER**  
**TO BE COMPLETED WHERE AN EMPLOYER PAYS CONTRIBUTIONS ON YOUR BEHALF**

Name of Employer : .....

Salary: 

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OFFICIAL EMPLOYER STAMP

The above-mentioned details have been noted and approved.  
Contributions will be appropriately adjusted in terms of the rules.

Signature : .....

Date 

Y	Y	Y	Y	M	M	D	D
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Designation : .....



**SECTION C : TO BE COMPLETED BY MEMBERS SELECTING MEDISAVE ESSENTIAL ONLY**

Please remember to include ID sized photographs of yourself and all dependants.  
Members changing to Medisave Essential UDIPA should also select a dentist and optometrist.

Principal Member				
Name	Date of birth	Doctor	Dentist (UDIPA)	Optometrist (UDIPA)
Dependant 1				
Name	Date of birth	Doctor	Dentist (UDIPA)	Optometrist (UDIPA)
Dependant 2				
Name	Date of birth	Doctor	Dentist (UDIPA)	Optometrist (UDIPA)
Dependant 3				
Name	Date of birth	Doctor	Dentist (UDIPA)	Optometrist (UDIPA)
Dependant 4				
Name	Date of birth	Doctor	Dentist (UDIPA)	Optometrist (UDIPA)
Dependant 5				
Name	Date of birth	Doctor	Dentist (UDIPA)	Optometrist (UDIPA)
Dependant 6				
Name	Date of birth	Doctor	Dentist (UDIPA)	Optometrist (UDIPA)
Dependant 7				
Name	Date of birth	Doctor	Dentist (UDIPA)	Optometrist (UDIPA)

Accredited by:



Administered by: **momentum** 

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A Member of:

