

OPTION SELECTION FORM

NB: ONLY COMPLETE THIS FORM IF YOU WANT TO **CHANGE** FROM YOUR CURRENT OPTION. PLEASE SUBMIT IMMEDIATELY TO ENSURE THAT THE FORM REACHES **MEDIMED** BY **10 DECEMBER 2021**.

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 2022	
Alpha	
Medisave Max	
Medisave Standard	

DECLARATION

- I hereby acknowledge that I am familiar with the conditions and benefits of the option selected, notwithstanding representation by another party.
- I understand that I must give written notice by 30 November 2021 of my intent to transfer to a new benefit option, which becomes effective 1 January 2022. I also accept that I can only change options once a year and will remain on this option until 31 December 2022.

Member's Signature: Date

Cell Number:

PLEASE NOTE:

- You are allowed to move from one option to another, once a year – i.e. on 1 January, each year.
- 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: