

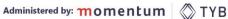
## **OPTION SELECTION FORM - FAURECIA**

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 30 NOVEMBER 2021

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

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Ι,		·····		·······		. (IIa	THE C	n me	ilibei	<i>)</i>						
Mer	embership No.															
wisł	sh to change to the following optic	n (pleas	se tick a	pprop	riate	box)	:									
	MEDIMED OPTION FOR 2022	2														
	Alpha															
	Medisave Max															
	Medisave Standard															
Medisave Essential (Complete Section C on 2 <sup>nd</sup> page)																
	DECLARATION															
1.	I hereby acknowledge that I are		ar with 1	he co	nditio	ns a	and b	enef	its of	the	optior	sele	cted,	notw	rithstar	nding
2.	representation by another party I understand that I must give w which becomes effective 1 Janu on this option until 31 December	ritten no uary 202														
	Member's Signature						Date									
	Cell Number :															
	PLEASE NOTE:															
	You are allowed to move from of the street o													mber	ship c	ard.









Therefore, prompt response in returning the option selection will be greatly appreciated.

4. For assistance with an option selection for 2022, please contact 010 590 5704.

3. Please email form to: medicalscheme2020@eohas.co.za

5. Late submissions will NOT be considered.





SECTION B: TO BE COMPLETED BY I	E <b>MPLOYER</b> (WHERE AN EMPLO	YER PAYS CONTRIBUTION	S ON YOUR BEHALF)

Name of Employer :					••••													
Salary:												OFFICIAL EMPLOYER STAMP						
The above-mentioned details have been noted and approved Contributions will be appropriately adjusted in terms of the rules.																		
Signature :	ature : Date Pate																	
Designation :																		

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

Kindly select your network below:

Medisave Essential PEGP	Medisave Essential ECIPA	

Please remember to include ID sized photographs of yourself and all dependants.

PRINCIPLE MEMBER		
Name	Date of Birth	Doctor
DEPENDENT 1		
Name	Date of Birth	Doctor
DEBENDENT		
DEPENDENT 2	D ( (B) (	5 /
Name	Date of Birth	Doctor
DEPENDENT 3		
Name	Date of Birth	Doctor
DEPENDENT 4		
Name	Date of Birth	Doctor
DEPENDENT 5		
Name	Date of Birth	Doctor
TVAITIO	Bate of Birth	200(0)
DEPENDENT 6		
Name	Date of Birth	Doctor



