Registration Number 1506
PO Box 1672 | Port Elizabeth | 6000
7 Lutman Road | Richmond Hill | Port Elizabeth | 6001
info@medimed.co.za | www.medimed.co.za
Fax: 041 395 4590 | ☎ 0861 777 660

Medimed
Managing your healthcare security

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 **30 NOVEMBER 2021.**

SECTION A: TO BE COMPLETED BY MEMBER

I, …… (name of member)

Membership No. | | | | | | | | | | | | |

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

MEDIMED OPTION FOR 2021	
Alpha	
Medisave Max	
Medisave Standard	
Medisave Essential (Complete Section C on 2nd 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 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:

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.
3. Please email form to: membership@medimed.co.za
4. For assistance with an option selection for 2022, please contact 0861 777 660
5. Late submissions will NOT be considered.

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SECTION B: TO BE COMPLETED BY EMPLOYER (WHERE AN EMPLOYER PAYS CONTRIBUTIONS 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: ……. Date

Y	Y	Y	Y	M	M	D	D

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
DEPENDENT 2		
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
DEPENDENT 6		
Name	Date of Birth	Doctor