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
☎ 0861 777 660 | Fax: 041 395 4590

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 2024.**

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 2025	
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 2024 of my intent to transfer to a new benefit option, which becomes effective 1 January 2025. I also accept that I can only change options once a year and will remain on this option until 31 December 2025.

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 2025, please contact 0861 777 660
5. If you are on Alpha and want to change to another option, you will need to submit an **income verification** form.
6. 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		Medisave Essential	

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