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 2023**.

## 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 2024 | |
|---|---|
| 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 2023 of my intent to transfer to a new benefit option, which becomes effective 1 January 2024. I also accept that I can only change options once a year and will remain on this option until 31 December 2024.

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.

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## SECTION B: TO BE COMPLETED BY EMPLOYER (TO BE COMPLETED 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: ……...

Designation: ……....

Date:

| Y | Y | Y | Y | M | M | D | D |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

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

Kindly select your network below:

| Medisave Essential PEGP | | Medisave Essential ECIPA | |
|---|---|---|---|

| **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 |
| | | |