

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 2020.

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 2021	
Alpha	<input type="checkbox"/>
Medisave Max	<input type="checkbox"/>
Medisave Standard	<input type="checkbox"/>
Medisave Essential (Complete Section C on 2 nd page)	<input type="checkbox"/>

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 2020 of my intent to transfer to a new benefit option, which becomes effective 1 January 2021. I also accept that I can only change options once a year and will remain on this option until 31 December 2021.

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 :

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

Please remember to include ID sized photographs of yourself and all dependants.
 Members changing to Medisave Essential UDIPA should also select a dentist and optometrist.

PRINCIPAL MEMBER				
Name	Date of Birth	Doctor	Dentist (UDIPA)	Optometrist (UDIPA)
DEPENDENT 1				
Name	Date of Birth	Doctor	Dentist (UDIPA)	Optometrist (UDIPA)
DEPENDENT 2				
Name	Date of Birth	Doctor	Dentist (UDIPA)	Optometrist (UDIPA)
DEPENDENT 3				
Name	Date of Birth	Doctor	Dentist (UDIPA)	Optometrist (UDIPA)
DEPENDENT 4				
Name	Date of Birth	Doctor	Dentist (UDIPA)	Optometrist (UDIPA)
DEPENDENT 5				
Name	Date of Birth	Doctor	Dentist (UDIPA)	Optometrist (UDIPA)
DEPENDENT 6				
Name	Date of Birth	Doctor	Dentist (UDIPA)	Optometrist (UDIPA)
DEPENDENT 7				
Name	Date of Birth	Doctor	Dentist (UDIPA)	Optometrist (UDIPA)