Be Smart. **Keep it Simple.**

KeyHealth MEDICAL SCHEME

86 Koranna Avenue Doringkloof Centurion 0157 | PO Box 14145 Lyttelton 0140 | Client Services: 0860 671 050 | Fax: 086 605 0656

Retirement

Membership Number

Instructions:

1. Please complete every section below in full. If not applicable, please write N/A in the appropriate field.
2. Copy of ID must be attached.
3. Any incomplete or illegible information will result in further enquiries, which could delay your request.
4. Membership is subject to the conditions, exclusions or limitations of benefits in accordance with the Medical Schemes Act and/or Scheme Rules.
5. Attach copy of the retirement form if applicable.

Section 1: Principal Member Personal Details

Title | Initials | First name

Surname

ID number (Y Y M M D D) | Gender: Male | Female

Race: African/Black (A) | Coloured (C) | White (W) | Indian/Asian (I) | Unknown (U)

Passport number | Marital status

Residential address

Postal code

Postal address (if different)

Postal code

Telephone - home (code - number) | Cellphone number

Telephone - work (code - number) | Fax - work (code - number)

E-mail address

Language preference: English | Afrikaans

Section 2: Option Choice

Important note: The member is only allowed to change option within 30 days of retirement

- Essence Option
- Origin Option
- Equilibrium Option
- Silver Option
- Gold Option
- Platinum Option

I request the Scheme to register me and my dependants from 0 1 – M M – 2 0 Y Y

Section 3: Banking Details for Payment of Contributions

Bank account holder	**KeyHealth Medical Scheme**
Name of financial institution	**ABSA**
Account number	**6 000 000 12**
Account type	**Cheque**
Branch code	**632005**
Reference	**Kindly use your membership number as reference**

Please fax proof of payment to 0860 111 390

Section 4: Method of Contribution Payments

Method of payment: Debit order ☐ Internet transfer ☐

***Please note that no credit card banking details will be accepted**

Section 4.1: Contribution Collection and Claims Reimbursements

Please indicate the choice of monthly debit order deduction date: **02** ☐ **07** ☐ **26** ☐ **Last day of month** ☐

☐ Use this account for **contribution collections** and **claims reimbursements**

☐ Use this account for **contribution collections** only

Name of account holder ____________________

Name of financial institution ____________________

Bank Branch code ☐☐☐☐☐☐☐☐

Type of Account: Cheque / Transmission / Savings

Bank account number ☐☐☐☐☐☐☐☐☐☐☐☐☐

***Please note that no credit card banking details will be accepted**

Account Holder Signature

Date D D – M M – 2 0 Y Y

☐ Use this account for **claims reimbursements** only

Name of account holder ____________________

Name of financial institution ____________________

Bank Branch code ☐☐☐☐☐☐☐☐

Type of Account: Cheque / Transmission / Savings

Bank account number ☐☐☐☐☐☐☐☐☐☐☐☐☐

***Please note that no credit card banking details will be accepted**

Account Holder Signature

Date D D – M M – 2 0 Y Y

Assignment

I hereby acknowledge that the party hereby authorise to effect the drawing(s) against my account may not cede or assign any of its rights to any third party without my consent and that I may not delegate any of my obligations in terms of ths contract/authority to any third party without prior written consent of the authorised party.

Note: Attach a copy of a cancelled cheque/ a recent bank statement/ an official bank letter from the bank to verify the banking details.

Account Holder Signature

Date D D – M M – 2 0 Y Y

Section 5: Employer Information - To be completed by employer

Will the member receive a monthly subsidy? **Yes** ☐ **No** ☐

What is the amount or percentage payable by the employer: ____________

Company Name ____________

SIGNATURE AND STAMP OF EMPLOYER

DESIGNATION

Date D D – M M – 2 0 Y Y

Signature of new Principal Member

Print Name and Surname of new Principal Member

Date D D – M M – 2 0 Y Y