MEDSHIELD
medical scheme

DEPENDANT TERMINATION REQUEST

Email: membership@medshield.co.za

Please note: Should your termination request reach the Scheme after the 7th of a month, your termination will only be effective at the end of the following month.

Principal Member Number:	
Principal Member ID Number:	
Principal Member Name/s:	
Principal Member Surname:	

SECTION A DEPENDANT/S TO BE TERMINATED

I hereby request that the following dependant(s) are terminated on my membership:

Dependant 1 First Name/s:	
Dependant 1 Surname:	
Termination Effective Date:	

Dependant 2 First Name/s:	
Dependant 2 Surname:	
Termination Effective Date:	

Dependant 3 First Name/s:	
Dependant 3 Surname:	
Termination Effective Date:	

MY REASON FOR TERMINATION RELATES TO:

Mark with an X where necessary.

Overage:	☐	Joining another medical aid:	☐
Affordability:	☐	Underwriting:	☐
Emigrating:	☐	Deceased : *(copy of Death Certificate my accompany this form)*	☐

Other: (Please specify) _____

_____

_____

Principal Member Signature: _____ Date: _____

SECTION B EMPLOYER APPROVAL (Companies/Group members only)

Name of Employer:

Paypoint Code:

Employee Payroll No.:

Termination Effective Date:

COMPANY STAMP

Tick this box if no Company Stamp is available ☐

By selecting this box you confirm that the Employer has granted approval ☐

Employer's Email Address:

Employer's Representative's Name:

Employer's Representative's Designation:

Date:

Employer's Representative's Signature: _____