

## CHANGE OF HEALTH PLAN OPTION

Please complete in block letters, tick appropriate blocks unless otherwise indicated

\*Please select an option you want to upgrade/degrade to:

Healthplan A  Healthplan B  Healthplan C  HealthPlan AS  Student Healthplan  A+  B+  C+

### About yourself (principal member)

Surname																			
First Name(s)																			
Gender	M	F	Date of Birth	D	D	M	M	Y	Y	Y	Y	Cell							
Marital Status: Married <input type="radio"/> Single <input type="radio"/> Divorced <input type="radio"/> Widowed <input type="radio"/>												Tel (H)							
Occupation																			
ID / passport number										Country of Issue									
Membership number										Basic Salary P									
Tel (W)										Fax									
Email																			
Postal Address					Village/Town										Physical Address				

\*Note Member may only transfer from one benefit to the other on the first day of the financial year provided they have given one(1) month written notice.

### Employer Confirmation

Name of Employer																			
Occupation										Date of employment									

### Employer warranty

We warrant that the main applicant detailed in the first section of this application form is an employee of our organisation and we are aware of the health plan and request.

Name

Designation

Email

Telephone

Postal Address



Authorised signatory \_\_\_\_\_ Signature of the Principal Member: \_\_\_\_\_

Member Banking details

Please note: we cannot accept credit card account details

Bank Name																										
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Branch Name																										
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Branch Code							Account Type																			
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Account Number																										
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Account Name																										
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By signing this application, you agree that claims will be refunded into the account you have chosen.