

Transfer from active to retiree status



Contact us

Tel: 0861 638 633 • PO Box 652509, Benmore, 2010 • www.netcaremedicalscheme.co.za

Who we are

Netcare Medical Scheme (referred to as 'the Scheme'), registration number 1584, which is registered with the Council for Medical Schemes. Discovery Health (Pty) Ltd (referred to as "the administrator") is a separate company and an authorised financial services provider (registration number 1997/013480/07), which takes care of the administration of your membership of Netcare Medical Scheme.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. This form is for main members who move onto retiree status and to make contributions or payments directly to Netcare Medical Scheme.
3. To avoid administration delays, please ensure this application is completed in full.
4. Once completed, please return this form to your Human Resources department.
5. Please call Netcare Medical Scheme on 0861 638 633 for any queries.

1. Member information (main applicant)

Membership number (compulsory)	<input type="text"/>	Start date	<input type="text"/>
Employee number (compulsory)	<input type="text"/>		
Title	<input type="text"/>	Initials	<input type="text"/>
Surname	<input type="text"/>		
First name/s	<input type="text"/>		
Preferred name	<input type="text"/>	Sex	<input type="text"/>
Date of birth	<input type="text"/>		
Marital status: Married	<input type="checkbox"/>	Single	<input type="checkbox"/>
Divorced	<input type="checkbox"/>	Widowed	<input type="checkbox"/>
Date of marriage	<input type="text"/>		
Previous/maiden name	<input type="text"/>		
ID or passport number	<input type="text"/>		
Country of issue	<input type="text"/>		
Telephone (H)	<input type="text"/>	(W)	<input type="text"/>
Fax	<input type="text"/>	Cellphone	<input type="text"/>
Email address	<input type="text"/>		
Postal address	<input type="text"/>		
			Code <input type="text"/>
Residential address	<input type="text"/>		
			Code <input type="text"/>

2. Banking details for your monthly contributions

What you must do

Submit the following with this form: A copy of your ID and a bank statement or letter of confirmation from the bank.

These details apply when you pay directly towards your total contribution. Please note that we cannot accept credit card details. You can only use a South African bank account. The first deduction will take place at the beginning of the month following the start date as a retiree member.

Bank name Branch name

Account type: Current Transmission Savings Branch code - -

Name of accountholder

Account number

Signature of accountholder

I _____, hereby give Discovery Health (Pty) Ltd and/or Netcare Medical Scheme permission to charge my bank account for my contributions to Netcare Medical Scheme.

3. Banking details for reimbursement of your claims

What you must do

Submit the following with this form: A copy of your ID and a bank statement or letter of confirmation from the bank.

Same as above? Yes No (if "No", please complete below)

Bank name Branch name

Account type: Current Transmission Savings Branch code - -

Name of accountholder

Account number

Signature of accountholder

4. Your legal declaration

It is my sole responsibility as a member to make sure Netcare Medical Scheme receives the monthly contributions. If contributions are outstanding for two months in a row, my membership will be cancelled in the third month. Short payment or non-payment of any of my contributions will result in suspension of my claims.

I confirm the content of this application is true and complete.

I agree to advise Netcare Medical Scheme in writing of any change in details, that may occur between the date of this application and the activation of my membership with Netcare Medical Scheme.

Signed at on

Signature of applicant

Please do not sign an incomplete application form

5. Your employment details

If your employer is paying your full contribution or a part of it, please complete this section:

Name of employer

Employer / billing number

Employee number Date of employment

1. Employer contact person <input type="text"/>	2. Employer contact person <input type="text"/>
Telephone <input type="text"/>	Telephone <input type="text"/>
Email <input type="text"/>	Email <input type="text"/>
Branch name <input type="text"/>	Branch number <input type="text"/>
Department name <input type="text"/>	Department number <input type="text"/>
Date of promotion (if applicable) <input type="text"/>	

Please ensure your employer completes this warranty.