



OPTION SELECTION FORM

PLEASE NOTE: OPTION CHANGES CAN ONLY BE EFFECTIVE FROM 1 JANUARY EACH YEAR. ENSURE THAT FORM REACHES SIZWE HOSMED MEDICAL SCHEME BY 11 DECEMBER.

PLEASE PRINT IN CAPITAL LETTERS. USE A BLACK PEN ONLY, PLEASE MARK APPROPRIATE CHOICE USING A CROSS (X)
NOTE : KINDLY CONSIDER THE ENCLOSED BROCHURE, SELECT YOUR OPTION AND ADVISE YOUR EMPLOYER AS SOON AS POSSIBLE

Broker Code

Broker Stamp

Broker No.

PLEASE COMPLETE APPROPRIATELY ALL THE SECTIONS BELOW IN FULL

SECTION A: MEMBER DETAILS

| | | | | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Membership number | | | | | | | | | |
| Name | | | | | | | | | |
| Surname | | | | | | | | | |
| Postal address | | | | | | | | | |
| | | | | | | | | Postal code | |
| Tel. no. (h) | | | (w) | | | | (Cell) | | |
| Identity no. | | | | | Email | | | | |
| Employer name | | | | | | | | | |
| Employee number | | | | | | | | | |
| Race (please tick) | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| African | Coloured | Indian/Asian | White | | | | | | |

SECTION B: OPTION CHANGE

Kindly consider the enclosed brochure. Make your option selection and advise your employer as soon as possible. This form must be submitted to your payroll department, where applicable for onward submission to the Scheme.

| | | | | | | | | | | | |
|---|-------------------------------|--|--|--------------------------------------|--|---------------------------------------|--|--|--|---|--|
| CURRENT OPTION | | | | | | | | | | | |
| Titanium Executive <input type="checkbox"/> | Plus <input type="checkbox"/> | Platinum Enhanced <input type="checkbox"/> | Platinum Enhanced EDO <input type="checkbox"/> | Gold Ascend <input type="checkbox"/> | Gold Ascend EDO <input type="checkbox"/> | Value Option <input type="checkbox"/> | Value Core Option <input type="checkbox"/> | Access Saver (25%) Option <input type="checkbox"/> | Access Saver (15%) Option <input type="checkbox"/> | Silver Hospital <input type="checkbox"/> | Essential Copper Option <input type="checkbox"/> |
| PREFERRED OPTION | | | | | | | | | | | |
| Titanium Executive <input type="checkbox"/> | Plus <input type="checkbox"/> | Platinum Enhanced <input type="checkbox"/> | Platinum Enhanced EDO <input type="checkbox"/> | Gold Ascend <input type="checkbox"/> | Gold Ascend EDO <input type="checkbox"/> | Value <input type="checkbox"/> | Value Core <input type="checkbox"/> | Access Saver (25%) Option <input type="checkbox"/> | Access Core <input type="checkbox"/> | Essential Copper <input type="checkbox"/> | |
| Reason for change (please tick appropriate) | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Financial | Benefits | Other | | | | | | | | | |

SECTION C: MEMBER DECLARATION

I confirm that I have chosen to change options on the Scheme, and that this declaration is based on advice received from _____

I confirm that I have made the choice of option after considering my personal requirements and those of my dependants and have not been influenced in any way by Sizwe Hosmed Medical Scheme. I confirm that to prevent the risk of concluding a transaction that is not appropriate to my needs, objectives and circumstances, I should obtain a full healthcare needs analysis.

- To ensure that my application form is submitted to my employer for processing.
- I agree to access www.hosmed.co.za to access full conditions and undertakings of the Scheme as a member of Hosmed Medical Scheme
 - Where applicable: Member Savings Account allocations will be pro-rated depending on the activation date.
 - The Scheme has the sole right to collect negative balances owed to the Scheme by the member even when member has terminated from the Scheme.
- To ensure that my application form is submitted to my employer for processing.

Employer sign-off

Date

Effective date of new option

Signature of member

Employer Name

Employer Signature

Employer Stamp

Date

Fund Declaration
As Sizwe Hosmed Medical Scheme we are strongly committed to protecting your personal data. We are required by POPIA to explain why and how we collect, use, and disclose your personal information, which may include health and financial information. Sizwe Hosmed Medical Scheme and its administrator (3Sixty Health (Pty) Ltd) will keep your information supplied to us in this application confidential. Acceptance of these terms and conditions is a requirement for activation and servicing of your medical scheme membership. You give us consent to process your personal information for the following purposes:

- a. Administration of your health care option;
- b. Provision of managed care services to you;

- c. Providing relevant information to a contracted third party;
- d. To profile and analyse risk;
- e. For research purposes and;
- f. To comply with legislation.

Please note that we will only share your information with a third party if you have granted us your consent for the disclosure of the information to such third party or if a contractual relationship exists in terms of which we are obliged to provide your information to such third-party. We may amend this notice from time to time, please check our website to inform yourself of any changes.