SIZWE HOSMED MEDICAL SCHEME
Your choice for quality care

TERMINATION OR REINSTATEMENT FORM

DISTRIBUTION OF ADVICE - ORIGINAL TO SIZWE HOSMED MEDICAL SCHEME - COPY TO BE RETAINED BY COMPANY

Paypoint number/code: _____

CODES:

01 = Company closed down/liquidated
02 = Scheme change within company
03 = Transfer from company to Direct Paying Member (DPM)
04 = Joined spouse's medical aid
05 = Member dissatisfied with service
06 = Death
07 = On pension
08 = Resigned from company
09 = Transferred to new employer group
10 = Company policy
11 = Dismissed from employment
12 = Member dissatisfied with benefits
13 = Retrenched
14 = Coverage costs too expensive
15 = Emigrating

SECTION 1 TERMINATION OF MEMBERSHIP

☐ Code Effective date: _____ Name and initials: _____

Member's medical aid number: _____

Payroll number: _____

☐ Code Effective date: _____ Name and initials: _____

Member's medical aid number: _____

Payroll number: _____

☐ Code Effective date: _____ Name and initials: _____

Member's medical aid number: _____

Payroll number: _____

☐ Code Effective date: _____ Name and initials: _____

Member's medical aid number: _____

Payroll number: _____

SECTION 2 REINSTATEMENT OF MEMBERSHIP

Effective date: _____ Name and initials: _____

Member's medical aid number: _____

Payroll number: _____

Effective date: _____ Name and initials: _____

Member's medical aid number: _____

Payroll number: _____

SECTION 3 DECLARATION BY EMPLOYER/DIRECT PAYING MEMBER

We/I confirm that the information is true and correct and that the relevant contribution adjustments will be effected on the appropriate contribution remittance/ debit order.

Signed: _____ Designation: _____

Date: _____ Email address: _____

Please note: Company must inform Sizwe of resignations on the date that the member resigns.

EMPLOYER'S STAMP