

MEMBERSHIP CHANGE FORM
To be used by registered members only

Member's details

Title: Mr Mrs Miss Ms

Membership number: _____

Surname:	First Name(s):
Employee Number:	Identity number:

1. ADDITION OF DEPENDANTS

- i. Newly born babies are to be registered within 3 month of birth. Application to be supported by a certified copy of either a birth confirmation record or birth certificate.
- ii. Newly married spouses are to be registered within 3 month of marriage. Application to be supported by a marriage certificate or an affidavit.
- iii. Please attach a medical aid membership certificate if the dependants are transferring from another medical aid society.
- iv. Late registration of children and/or spouses requires that the spouse/child undergoes a medical examination by a medical practitioner selected by the Fund. The applicant will meet the costs of the medical examination. Membership admission will be at the discretion of the Fund and if granted waiting periods will apply.

Surname	First Name(s)	Sex	Date of Birth	Identity Number	Relationship	Effective Date

2. CANCELLATION OF MEMBERSHIP / DELETION OF DEPENDANTS

- i. MSA credit balances will be reimbursed 4 months from the date of termination.
- ii. MSA reimbursement cheques will be paid to your employer who will then pass them onto you.

Surname	First Name(s)	Membership Number & Suffix	Relationship	Reason for terminating membership	Effective Date

3. CHANGE OF A.A.C.M.A.S. MSA CONTRIBUTION LEVEL OPTION

- i. MSA contribution levels may be changed at any time.

Current Medical Savings Account Contribution Option

<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High	<input type="checkbox"/> Super High
<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High	<input type="checkbox"/> Super High

New Selected Medical Savings Account Contribution Option

<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High	<input type="checkbox"/> Super High
<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High	<input type="checkbox"/> Super High

Effective date of MSA change: _____

Applicant's Signature: _____ Date: _____

EMPLOYER INFORMATION (TO BE COMPLETED BY EMPLOYER REPRESENTATIVE)

Name of Employer Representative:	Signature of Employer Representative:
Date:	Official company stamp:

FOR SOVEREIGN USE ONLY

Actioned by:	
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