

OPTION SELECTION FORM

1. Only complete this form if you want to change from your current option. Please submit it immediately to your employer to ensure the form reaches Sizwe Medical Fund by 14 December.

SECTION 1

TO BE COMPLETED BY MEMBER

I, _____ (Name of member)

Membership Number.

Wish to change to the following option (please tick appropriate box):

Medical Fund Options: Hospital Care Gomomo Care Primary Care Affordable Care Full Benefit Care

Please read the following instructions before submitting your option change form.

Group members:

Return your completed option change form to your employer's HR or Payroll Office. The HR or Payroll Office must sign and stamp the form and return it to the Sizwe branch that administers your company's membership.

Note: Option change forms for members within a company are subject to approval by the employer. Only forms that are signed and stamped by your company's HR/Payroll Office will be accepted and processed.

Direct-paying members:

Return your completed option change form to the Sizwe branch that administers your membership. (Please see relevant contact details and email on the back of this form.)

Pensioners:

Return your completed option change form to your pension administrator or the nearest Sizwe branch. (Please see relevant contact details and email on the back of this form.)

Note: The pension administrator must sign and stamp the form and return it to the Sizwe branch. Option change forms that are not signed and stamped by your pension administrator will not be accepted. The option change form must be submitted with your ID and proof of income, if proof is not received the income will be based on the highest category of the chosen option.

SECTION 2 (a)

TO BE COMPLETED BY EMPLOYER

Name of employer: _____

Salary R:

The above details have been noted and approved.
Contributions will be appropriately adjusted in terms of the rules.

Employer's signature: _____

Designation: _____

Date:

COMPANY STAMP

SECTION 2 (b)

TO BE COMPLETED BY DIRECT-PAYING MEMBERS

Name of Pension Fund (where applicable): _____

Salary R: Income category: Please refer to the Benefit Guide

I declare that the above details are correct and attach proof of income (e.g. salary slip, tax return, SARS 1T34, auditor's certificate).

Member's Signature: _____ Date:

VERY IMPORTANT: Option changes will not be accepted after the closing date of

PLEASE NOTE:

1. You are allowed to move from one option to another once a year - i.e. on 1 January each year
2. You retain your membership number as a member number for life. The new option does not mean a new membership number.

Completed forms and supporting documents may be emailed to:
Optionchange@sizwe.co.za or Faxes to 011 353 0267 (Both employer groups and direct paying members).

DECLARATION AND ACCEPTANCE OF RESPONSIBILITY

I understand that I must give written notice by 14 December of my intention to transfer to a new benefit option in the following year, which becomes effective on the first day of January following submission of my option selection.

I accept that I can only change options once a year and will remain on this option until 31 December of that year.

I understand and accept that the option change might affect my current benefits and I take responsibility for the consequences of any benefit changes as a result of option changes. I understand that I am responsible for payment in full of the monthly contributions on my new option.

Member's Signature: _____

Date:

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