Please fax completed applications to 021 7978856 or email it to enquiries@classmed.co.za

TERMINATION OF CORPORATE MEMBERSHIP / DEPENDANT
BEËINDIGING VAN KORPORATIEWE LIDMAATSKAP / AFHANKLIKE

1. DETAILS OF MEMBER / BESONDERHEDE VAN LID

This form is to be completed by members who wish to advise the Scheme of termination of membership. Should a member terminate membership of the Scheme and not be admitted as a member of another medical scheme, or be admitted to membership of another medical scheme which does not provide for a Personal Medical Savings Account (PMSA), the balance due to the member, including interest earned, must be refunded to the member five (5) months after termination of membership, subject to receiving the required documentation and will be subject to applicable laws.

Hierdie vorm moet deur lede wat die Skema in kennis wil stel van die beëindiging van hul lidmaatskap ingevul word. Indien 'n lid, hul lidmaatskap aan die Skema wil beëindig, en nie lid word van 'n ander skema nie, of lidmaatskap aanvaar van 'n ander mediese skema wat nie voorsiening maak vir 'n Persoonlike Mediese Spaarrekening (PMSR) nie, sal die balans, verskuldig aan die lid, insluitende rente wat verdien word aan die lid terugbetaal word binne vyf (5) maande na die beëindiging van lidmaatskap. Indien die vereiste dokumentasie ontvang word. Dit is onderhewig aan toepaslike wette.

Membership number
Lidmaatskapnommer

Employee number
Werknemernommer

Title
Titel

Surname
Van

Full names
Volle name

Current employer
Huidige werkgewer

☐ I hereby tender my resignation and that of all my dependants from Bestmed effective from
Hiermee gee ek kennis van my en al my afhanklikes se bedanking van Bestmed vanaf

or/ of

☐ I hereby tender the resignation of my dependant/s:
Hiermee gee ek kennis van die bedanking van my afhanklike/s:

First name Voorname	ID/ Passport number ID/ Paspoortnommer	Resignation date Bedankingsdatum

2. REASON FOR TERMINATION / REDE VIR BEËINDIGING

Please indicate the relevant reason(s) with an 'X'.

☐	Affordability (contributions too high) Bekostigbaarheid (bydrae te hoog)	☐	Death Afsterwe	☐	Resign from employer - compulsory scheme at new employer Bedank van werkgewer - verpligte skema by nuwe werkgewer
☐	Benefits (insufficient benefits/cover) Voordele (onvoldoende voordele/dekking)	☐	Emigration Emigrasie	☐	Join spouses medical aid Sluit aan by gade se mediese fonds
☐	Dependant over the age of 21 years Afhanklike oor die ouderdom van 21-jaar	☐	Misrepresentation Wanvoorstelling	☐	Administration (service related, process related, lack of communication) Administrasie (diensverwant, prosesverwant, onvoldoende kommunikasie)
☐	Marital status (divorce, marriage or joining spouse's medical scheme) Huwelikstatus (geskei, getroud of aansluit by eggenoot se mediese skema)	☐	Retrenchment Aflegging	☐	Access to service providers * Pulse 1 members - access to GPs or service providers * Other options - Scheme not known to providers Toegang tot diensverskaffers * Pulse 1 lede - toegang tot algemene praktisyns of diensverskaffers * Ander opsies - Skema is nie bekend aan diensverskaffers nie

I will be joining the following medical scheme/ Ek sluit aan by die volgende mediese skema

Please forward my membership certificate to (postal or e-mail)
Stuur asb my lidmaatskapsertifikaat na (pos of e-pos)

From
Vanaf

Code
Kode

Email address
E-pos adres

Telephone number (w)
Telefoonnommer (w)

Cell phone number
Selfoonnommer

Signed by me/
Onderteken deur my

Signature of principal member/
Handtekening van hooflid

on this/
op die

day of/
dag van

month/ maand Y Y Y Y

• Block A, Glenfield Office Park, 361 Oberon Avenue, Faerie Glen, Pretoria, 0081, RSA • PO Box 2297, Pretoria, 0001, RSA
• Client Service 086 000 2378 • Fax +27 (0)12 472 6500 • E-mail service@bestmed.co.za • www.bestmed.co.za • Reg no. 1252

3. STATEMENT BY EMPLOYER / VERKLARING DEUR WERKGEWER

To be completed by Employer **(ALL FIELDS COMPULSORY)** / Moet deur werkgewer voltooi word **(ALLE VELDE VERPLIGTEND)**

Employer name
Naam van werkgewer

Employee number
Werknemernommer

HR practitioner details
Menslikehulpbronne-praktisyn besonderhede

Surname
Van

Full names
Volle name

E-mail
E-pos

Telephone number
Telefoonnommer

Remarks/ Kommentaar

Signature of HR practitioner/ Handtekening van MH-praktisyn

Date
Datum

Name stamp of employer/ Naamstempel van werkgewer