

# CORPORATE GROUPS

## CANCELLATION OF MEDICAL SCHEME

Date: \_\_\_\_\_

To: \_\_\_\_\_ Medical Aid

Membership Number: \_\_\_\_\_

Employee No: \_\_\_\_\_

I \_\_\_\_\_, would hereby like to cancel my membership with the above medical scheme with cover up to 31/12/2019.

Thanking You

\_\_\_\_\_  
(Employee Signature)

Contact No: \_\_\_\_\_ Email: \_\_\_\_\_

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**Signature of HR Practitioner must be included below**

**HR Practitioner: \_\_\_\_\_ Signature: \_\_\_\_\_**