CORPORATE GROUP
DISCOVERY HEALTH OPTION CHANGE FORM 2020

Date: _______________

Membership Number: ____________________

Employee No: _______________________

I ___________________________________, would hereby like my option with Discovery Medical Aid to be changed from 1 January 2020 to:

Name of New Option ____________________

Thanking You

____
(Employee Signature)

Contact No: _______________________ Email: ______________________________

Signature of HR Practitioner must be included below

HR Practitioner: ____________________________ **Signature:** ___________________