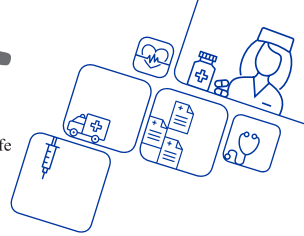


Postal address PO Box 16148, Doornfontein, 2028
 Share Call 0860 00 0048
 Fax 086 608 0771
 E-mail membership@hosmed.co.za



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

OPTION SELECTION FORM

PLEASE NOTE: OPTION CHANGES CAN ONLY BE EFFECTIVE FROM 1 JANUARY EACH YEAR

PLEASE PRINT IN CAPITAL LETTERS. USE A BLACK PEN ONLY, PLEASE MARK APPROPRIATE CHOICE USING A CROSS (X)
 NOTE : KINDLY CONSIDER THE ENCLOSED BROCHURE, SELECT YOUR OPTION AND ADVISE YOUR EMPLOYER AS SOON AS POSSIBLE

Broker Code **H O S M E D 1 0 0 1 3 4**

Broker Stamp

PLEASE COMPLETE APPROPRIATELY ALL THE SECTIONS BELOW IN FULL

SECTION A: MEMBER DETAILS

Membership number									
Name									
Surname									
Postal address									
								Postal code	
Tel. no. (h)			(w)				(Cell)		
Identity no.					Email				
Employer name									
Employee number									
Race (please tick)									
<input type="checkbox"/> African		<input type="checkbox"/> Coloured		<input type="checkbox"/> Indian/Asian		<input type="checkbox"/> White			

SECTION B: OPTION CHANGE

Kindly consider the enclosed brochure. Make your option selection and advise your employer as soon as possible. This form must be submitted to your payroll department, where applicable for onward submission to the Scheme.

CURRENT OPTION				PREFERRED OPTION				
Plus <input type="checkbox"/>	Value <input type="checkbox"/>	Access* <input type="checkbox"/>	Essential <input type="checkbox"/>	Plus <input type="checkbox"/>	Value <input type="checkbox"/>	Value Core <input type="checkbox"/>	Access* <input type="checkbox"/>	Essential <input type="checkbox"/>

**Please note that the Access Option has a 20% Medical Savings Account*

Reason for change (please tick appropriate)	<input type="checkbox"/> Financial	<input type="checkbox"/> Benefits	<input type="checkbox"/> Other
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SECTION C: MEMBER DECLARATION

I confirm that I have chosen to change options on the Scheme, and that this declaration is based on advice received from

I confirm that I have made the choice of option after considering my personal requirements and those of my dependants and have not been influenced in any way by Hosmed Medical Scheme. I confirm that to prevent the risk of concluding a transaction that is not appropriate to my needs, objectives and circumstances, I should obtain a full healthcare needs analysis.

- To ensure that my application form is submitted to my employer for processing.
- I agree to access www.hosmed.co.za to access full conditions and undertakings of the Scheme as a member of Hosmed Medical Scheme.
- Where applicable: Member Savings Account allocations will be pro-rated depending on the activation date.
- The Scheme has the sole right to collect negative balances owed to the Scheme by the member even when member has terminated from the Scheme.

 Employer sign-off

 Date

 Effective date of new option

 Signature of member

 Employer Name

 Employer Signature

 Employer Stamp

 Date