

TERMINATION OR REINSTATEMENT FORM



DISTRIBUTION OF ADVICE – ORIGINAL TO SIZWE MEDICAL FUND – COPY TO BE RETAINED BY COMPANY

Paypoint number/code: _____

- CODES:**
- | | | |
|--|--|--|
| 01 = Company closed down/liquidated | 05 = Member dissatisfied with service | 11 = Dismissed from employment |
| 02 = Scheme change within company | 06 = Death | 12 = Member dissatisfied with benefits |
| 03 = Transfer from company to Direct Paying Member (DPM) | 07 = On pension | 13 = Retrenched |
| 04 = Joined spouse's medical aid | 08 = Resigned from company | 14 = Coverage costs too expensive |
| | 09 = Transferred to new employer group | 15 = Emigrating |
| | 10 = Company policy | |

SECTION 1 TERMINATION OF MEMBERSHIP

Code Effective date: DD / MM / YYYY Name and initials: _____

Member's medical aid number:

Payroll number:

Code Effective date: DD / MM / YYYY Name and initials: _____

Member's medical aid number:

Payroll number:

Code Effective date: DD / MM / YYYY Name and initials: _____

Member's medical aid number:

Payroll number:

Code Effective date: DD / MM / YYYY Name and initials: _____

Member's medical aid number:

Payroll number:

SECTION 2 REINSTATEMENT OF MEMBERSHIP

Effective date: DD / MM / YYYY Name and initials: _____

Member's medical aid number:

Payroll number:

Effective date: DD / MM / YYYY Name and initials: _____

Member's medical aid number:

Payroll number:

SECTION 3 DECLARATION BY EMPLOYER/DIRECT PAYING MEMBER

We/I confirm that the information is true and correct and that the relevant contribution adjustments will be effected on the appropriate contribution remittance/debit order.

Signed: _____ Designation: _____

Date: _____ Email address: _____

Please note: Company must inform Sizwe of resignations on the date that the member resigns.

