CORPORATE GROUP
DISCOVERY HEALTH OPTION CHANGE FORM 2024

Date: _______________

Membership Number: ____________________

Employee No: _______________________

I ___________________________________, would hereby like my option with Discovery Medical Aid

to be changed from 1 January 2024 to:

Name of New Option ____________________

Thanking You

____
(Employee Signature)

Contact No: _______________________ Email: ______________________________

EMPLOYER SECTION - Signature of HR Practitioner & Stamp must be included below

HR Practitioner Name : ___________________________ Signature: ___________________

Date __________________