MEDSHIELD
medical scheme

OPTION CHANGE REQUEST

Email: optionchange@medshield.co.za

Option changes as per the Scheme Rules may only be made effective 1 January of a benefit year, provided that the request is received by the Scheme no later than 31 December. No late submission or mid-year option changes will be permitted.

Understanding the exact benefits on the option you are considering (including prescribed minimum benefits, chronic medication and the medicine formulary, Day-to-Day, dental, optical benefits, and hospitalisation), is a task best undertaken with the advice and guidance of your financial advisor.

Changing to a lower benefit option will result in lesser benefits and there may be a significant impact on how your chronic medication will be covered as opposed to the formularies used by your previous option. This could lead to more out-of-pocket expenses due to certain medication/s not covered on your new option and certain benefit limits on certain options only cover PMBs, meaning that non-PMB conditions and or procedures will not be covered.

It is also important to consider the choice of network providers, as certain benefit options allow you to choose freely while other options are network restricted.

Please ensure that you have read and understood the benefits of your selected option together with your financial advisor to ensure your choice of benefit option best suits your medical and financial needs before you make your selection.

Please complete all the relevant sections of this form in BLOCK LETTERS.

SECTION A — TO BE COMPLETED BY PRINCIPAL MEMBER OF THE SCHEME

Membership Number:

Member Name:

Member Surname:

ID/Passport Number:

Please provide at least one email address:

Personal Email Address:

Business Email Address:

Cell Number:

SECTION B — CHANGING OF BENEFIT OPTION

From Option:

To Option:

If you have selected MediPhila, MediCurve or one of the Compact benefit options, it is compulsory for you and your dependants to nominate a Family Practitioner (FP). IF YOU DO NOT NOMINATE A FAMILY PRACTITIONER (FP) AS PER THE CRITERIA LISTED PER OPTION BELOW, YOUR OPTION CHANGE FORM WILL NOT BE PROCESSED BY THE SCHEME.

MediPhila: Each beneficiary MUST nominate only ONE (1) Family Practitioner from the MediPhila Family Practitioner Network to a maximum of two (2) Family Practitioners per family.

MediCurve: Each beneficiary must nominate only ONE (1) Family Practitioner from the MediCurve Family Practitioner (FP) Network.

MediValue Compact & MediPlus Compact: Each beneficiary MUST nominate ONE (1) Family Practitioner (FP) which MUST be from the Compact Family Practitioner (FP) Network.

MediValue Prime and MediPlus Prime: Voluntary - Can nominate a FP which MUST be from the FP network to a MAXIMUM of two (2) FP's per beneficiary. *Where an FP was nominated from the FP Network & the Day-to-Day Limit is depleted, the member will qualify for an additional 2 visits per FAMILY from OAL.*

The registered networks per option are available on the website, please visit: www.medshield.co.za

NOMINATE A FP AS PER THE CRITERIA LISTED PER OPTION ABOVE:

Beneficiary	Beneficiary Name	Nominated Family Practitioner Name	Practice Number / Telephone
Principal Member		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 1		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 2		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 3		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 4		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 5		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 6		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 7		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY

SECTION C — COMPANY APPROVAL

(if your contributions are paid via your employer this section MUST be completed.) (NOT FOR PERSAL MEMBERS)

Company Name:

Telephone Number:

Company Email Address:

Effective Date: 0 1 0 1 2 0 2 2

HR Representative Name:

HR Representative's Signature: _____

COMPANY STAMP

If no Company Stamp is available, please mark this block with an X.

SECTION D — MEMBER DECLARATION

All boxes must be ticked as confirmation that you have read, understood and agree with the terms as stated.

I, _____ (Principal Member's full name) the undersigned, hereby give Medshield Medical Scheme the authority to make the change upon receiving my signed form and acknowledge that:

- ☐ Details contained herein are true and accurate
- ☐ I acknowledge that I am familiar with the benefits and rules of my new chosen benefit option
- ☐ I understand how the benefit option change will impact my cover and benefits and I take responsibility for the consequences of any benefit changes as a result of the option change
- ☐ I acknowledge that I have received advise from my financial advisor / or am exercising this change by my own informed choice
- ☐ I am aware that once I have decided to move to another benefit option as per the Scheme Rules, I will not be allowed to reverse this decision during the 2024 benefit year.

Please note that should your option change reach us after our contribution collection cut-off date of 15 December 2023:

- That you are at risk of the Scheme possibly only deducting your correct contribution in February 2024.
- If your option change result in a credit due to you, the credit will be offset against your February 2024 contribution. Please note that the Scheme will not refund these credits directly into your bank account.

Principal Member Signature: _____ Date: D D M M Y Y Y Y

Completed option change can be submitted via e-mail to optionchange@medshield.co.za.