CORPORATE GROUP
DISCOVERY HEALTH OPTION CHANGE FORM 2027

Date: _____

Discovery Membership Number: _____

Employee Number: _____

I _____, ID Number _____

Hereby request that my medical aid option with Discovery Health be changed effective **1 January 2026** to:

New Option Name _____

Thanking You

_____
(Employee Signature)

Contact No: _____ Email: _____

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

HR Practitioner Name : _____ Signature: _____

Date _____