DISCOVERY HEALTH OPTION CHANGE FORM 2027 (PRIVATE CLIENTS)

Date: _____

Discovery Membership Number: _____

I _____, ID Number _____

Hereby request that my medical aid option with Discovery Health be changed effective **1 January 2027** to:

New Option Name _____

Thanking You

_____
(MEMBER SIGNATURE)

Contact No: _____ Email: _____