MEDSHIELD
medical scheme

DEPENDANT TERMINATION REQUEST

Email: membership@medshield.co.za

Please note: Should your termination request reach the Scheme after the 7th of a month, your termination will only be effective at the end of the following month.

Principal Member Number:

Principal Member ID Number:

Principal Member Name/s:

Principal Member Surname:

SECTION A DEPENDANT/S TO BE TERMINATED

I hereby request that the following dependant(s) are terminated on my membership:

Dependant 1 First Name/s:

Dependant 1 Surname:

Termination Effective Date: D D M M Y Y Y Y

Dependant 2 First Name/s:

Dependant 2 Surname:

Termination Effective Date: D D M M Y Y Y Y

Dependant 3 First Name/s:

Dependant 3 Surname:

Termination Effective Date: D D M M Y Y Y Y

MY REASON FOR TERMINATION RELATES TO:

Mark with an X where necessary.

Overage: ☐

Affordability: ☐

Emigrating: ☐

Joining another medical aid: ☐

Underwriting: ☐

Deceased : ☐
(copy of Death Certificate my accompany this form)

Other: (Please specify) _____

_____

_____

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

SECTION B EMPLOYER APPROVAL (Companies/Group members only)

Name of Employer:

Paypoint Code:

Employee Payroll No.:

Termination Effective Date: D D M M Y Y Y Y

COMPANY STAMP

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

Employer's Email Address:

Employer's Representative's Name:

Employer's Representative's Designation:

Date: D D M M Y Y Y Y

Employer's Representative's Signature: _____