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hosmed medical scheme care for life

SALGA FREEDOM OF ASSOCIATION MEMBERSHIP APPLICATION FORM

PLEASE PRINT IN CAPITAL LETTERS. USE A BLACK PEN ONLY, PLEASE MARK APPROPRIATE CHOICE USING A CROSS (x)

Membership Number	
Department	
Depot	
Tel	
Municipality name	Broker

Broker Stamp

SECTION A: MEMBER DETAILS

Title: Mr/Mrs/Miss		Initials		First name	
Surname				Identity no.	
Tel. no. (h)		(w)		(Cell)	
Email					
Residential address					
				Postal code	
Postal address					
				Postal code	

SECTION B: HOSMED MEMBERSHIP DETAILS

Preferred option				Payroll no.	
Join date		Total contribution	R	Gross monthly salary	R

SECTION C: PARTICULARS OF DEPENDANTS

Dependants	Name	Surname	Gender	ID number	Relationship (compulsory)
Spouse					
Child 1					
Child 2					
Child 3					
Child 4					

SECTION D: BANK DETAILS (FOR CLAIMS REFUND)

Account holder						
Account number		Account type (please mark appropriate)	Current	Transmission	Savings	
Name of bank		Branch code				

I acknowledge that:

(a) I am aware that, once I have decided to move to another medical aid scheme – for which provision is made by my employer – I will not be allowed to move to another scheme during the next 12 months.

(b) The onus rests with me to ensure that my application is submitted to my Support Services Division.

(c) I must register my chronic medication with Hosmed.

Signature of member | Employer Name | Employer Signature | Employer Stamp | Date