

Dependant withdrawal request form 2021

This form is to be used when withdrawing dependants on the membership only.



Contact details

Tel: 0860 100 698 • PO Box 8012, Greenstone 1616 • www.malcormedicalaid.co.za

Who we are

The Malcor Medical Aid Scheme (referred to as 'the Scheme'), registration number 1547. This is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). We take care of the administration of your membership for the Scheme.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. This form needs to be completed to withdraw the membership of your dependant/s.
3. To avoid administration delays, please ensure this application is completed in full.
4. To be completed and returned to your Human Resources department via email to **membership@totalmed.co.za** or fax to 011 372 1578.

1. Employer contact details (to be completed by employer)

Person who will receive correspondence on the application process

Employer contact name	<input type="text"/>	Designation	<input type="text"/>
Telephone	<input type="text"/>	Fax	<input type="text"/>
Email address	<input type="text"/>		
Preferred means of communicating (please tick one)	Email <input type="checkbox"/>	Post <input type="checkbox"/>	Fax <input type="checkbox"/>

2. Principal Member Details

Member name	<input type="text"/>	Membership number	<input type="text"/>
Employee number	<input type="text"/>	Contact number	<input type="text"/>

3. Withdrawals

Effective Date

Please note - No backdated withdrawals allowed. All withdrawals need to be submitted three weeks in advance.

Initials and surname	Date of Birth	Participation status	Reason
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

4. Postal Address For Future Correspondence

Postal address	<input type="text"/>
	<input type="text"/>
	Code <input type="text"/>

MALDWR001

Principal member
signature

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Date

Y	Y	Y	Y	M	M	D	D
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**The Principal member must sign and date any changes
Please do not sign an incomplete application form**