Transfer from active to retiree status

MALCOR
MEDICAL AID SCHEME
Administered by Discovery Health

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, 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 is for main members who move onto individual status, to make contributions or payments directly to Malcor Medical Aid Scheme.

3. To avoid administration delays, please ensure this application is completed in full.

4. To be completed and returned to your Human Resources department. Human Resources in turn will email **membership@totalmed.co.za** or fax to **011 372 1578**.

5. Please call Malcor Medical Aid Scheme on 0860 100 698 for any queries.

1. Details of Principal member

Membership number (compulsory) Start date D D M M Y Y Y Y

Employee number (compulsory)

Title Initials Surname

First name(s)

Preferred name Gender M F Date of birth D D M M Y Y Y Y

Marital status: Married Single Divorced Widowed Date of marriage D D M M Y Y Y Y

Previous/maiden name

ID or passport number

Country of issue

Telephone (H) (W)

Fax Cellphone

Email address

Postal address

Code

Residential address

Code

Please note that this form expires on 31/03/2023. Up to date forms are available on www.malcormedicalaid.co.za.

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2. Banking details for your monthly contributions

What you must do

Submit the following with this form: A copy of your ID and a bank statement/letter of confirmation from the bank.

These details apply when you pay directly towards your total contribution. Please note that we cannot accept credit card details. You may only use a South African bank account. The first deduction will take place at the beginning of the month following the start date as a retiree member.

Bank name ______ Branch name ______

Account type Current ☐ Transmission ☐ Savings ☐ Branch code ______

Name of accountholder ______

Account Number ______

Signature of account holder ______

I, ______, hereby give

Discovery Health (Pty) Ltd and/or Malcor Medical Aid Scheme permission to charge my bank account for my contributions to Malcor Medical Aid Scheme.

3. Banking details for reimbursement of your claims

What you must do

Submit the following with this form: A copy of your ID and a bank statement/letter of confirmation from the bank

Same as above? Yes ☐ No ☐ (if "No" please complete below)

Bank name ______ Branch name ______

Account type Cheque ☐ Savings ☐ Branch code ______

Name of account holder ______

Account Number ______

Signature of account holder ______

4. Your legal declaration

It is my sole responsibility as a member to make sure Malcor Medical Aid Scheme receives the monthly contribution. If contributions are outstanding for two months in a row, my membership will be cancelled in the third month. Short payment or non-payment of any of my contributions will result in suspension of my claims.

I confirm the content of this application is true and complete.

I agree to advise Malcor Medical Aid Scheme in writing of any change in details that may occur between the date of this application form and the activation of my membership with Malcor Medical Aid Scheme.

Signed at ______ on Y Y Y Y M M D D

Signature of applicant ______

Please do not sign an incomplete application form

5. Your employment details

If your employer is paying your full contribution or a part of it, please complete this section:

Name of employer

Employer / billing number

Employee number

Date of employment D D M M Y Y Y Y

1. Employer contact person

Telephone

Email

Branch name

Department name

2. Employer contact person

Telephone

Email

Branch name

Department number

Date of promotion (if applicable) D D M M Y Y Y Y

Please ensure your employer completes this warranty.