

Transfer from active to retiree status

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 or complete digitally.
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)	<input type="text"/>	Start date	<input type="text"/>
Employee number (compulsory)	<input type="text"/>		
Title	<input type="text"/>	Initials	<input type="text"/>
Surname	<input type="text"/>		
First name/s	<input type="text"/>		
Previous/maiden name	<input type="text"/>		
Gender	M <input type="checkbox"/> F <input type="checkbox"/>	Date of birth	<input type="text"/>
Marital status	Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>	Date of marriage	<input type="text"/>
ID or passport number	<input type="text"/>		
Telephone (H)	<input type="text"/>	Telephone (W)	<input type="text"/>
Cellphone	<input type="text"/>	Fax	<input type="text"/>
Email	<input type="text"/>		
Postal address	<input type="text"/>		
		Code	<input type="text"/>
Residential address	<input type="text"/>		
		Code	<input type="text"/>

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	<input type="text"/>	Branch name	<input type="text"/>
Account type	Current <input type="checkbox"/> Transmission <input type="checkbox"/> Savings <input type="checkbox"/>	Branch code	<input type="text"/> - <input type="text"/> - <input type="text"/>
Name of account holder	<input type="text"/>		
Account Number	<input type="text"/>		
Signature of account holder	<input type="text"/>		

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	<input type="text"/>	Branch name	<input type="text"/>
Account type	Current <input type="checkbox"/> Transmission <input type="checkbox"/> Savings <input type="checkbox"/>	Branch code	<input type="text"/> - <input type="text"/> - <input type="text"/>
Name of account holder	<input type="text"/>		
Account Number	<input type="text"/>		
Signature of account holder	<input type="text"/>		

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	<input type="text"/>											
Employer / billing number	<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"/>
Employee number	<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"/>
Date of employment	<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"/>

1. Employer contact person	<input type="text"/>	2. Employer contact person	<input type="text"/>
Telephone	<input type="text"/>	Telephone	<input type="text"/>
Email	<input type="text"/>	Email	<input type="text"/>
Branch name	<input type="text"/>	Branch name	<input type="text"/>
Department name	<input type="text"/>	Department number	<input type="text"/>

Date of promotion (if applicable)

Please ensure your employer completes this warranty.