

Member withdrawal request form



Contact details
Tel: 0860 002 133 • www.sabmas.co.za

Who we are

SAB Medical Aid (referred to as 'the Scheme'), registration number 1209, is a not-for-profit organisation, registered with the Council for Medical Schemes. Discovery Health (Pty) Ltd, registration number 1997/013480/07, (referred to as 'the Administrator') is a separate company and an authorised financial services provider and is responsible for the administration of your membership on behalf of the Scheme.

To be completed and returned to your Payroll Administrator.

Print clearly using CAPITAL letters and one character per block. Alternatively, complete electronically by completing the fields below.

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

Please give us the details of the person who should receive correspondence on the withdrawal process

Contact name																
Designation																
Telephone																
Email																
Employer signature								Date	D	D	M	M	Y	Y	Y	Y

2. Principal member's details

Membership number															
ID or passport number															
Member's surname															
Member's name															

3. Withdrawal

Effective date	D	D	M	M	Y	Y	Y	Y		
Membership withdrawal	☐									
Dependant withdrawal	☐									
Reason for withdrawal (please tick)	Marriage	☐							Left employment (no longer employed)	☐
	Retirement	☐							Transfer to a new medical aid	☐
	Divorced/Separated	☐							Emigration	☐
	Dismissed	☐							Death (please supply death certificate)	☐
	Dependant withdrawal	☐								
☐ Other (please specify)										

For a dependant withdrawal please complete the section below.

No backdated withdrawals are allowed. All withdrawals need to be submitted a month in advance. If submitted mid-month, the full contribution will be charged for the month.

Initials and surname	ID or passport number	Effective date
		D D M M Y Y Y Y
		D D M M Y Y Y Y
		D D M M Y Y Y Y
		D D M M Y Y Y Y
		D D M M Y Y Y Y
		D D M M Y Y Y Y
		D D M M Y Y Y Y

4. Banking details (for Medical Savings Account payback, if applicable)

COMPULSORY FOR MEMBERS ON THE COMPREHENSIVE OPTION TO COMPLETE SAVINGS TRANSFER

Note: The Medical Scheme Act requires that your medical scheme savings account balances must be transferred to your next medical aid. Only in the event that you are not joining a new medical scheme or that medical scheme does not have a savings option, may a cash refund be made to you. If you are joining another medical scheme within the next four months, please complete the details of that scheme below or let us know these details as soon as you have them.

New medical scheme details

Membership number

New medical scheme details

I am not joining another medical aid, therefore, please pay out the savings to this bank account. Please find attached copy of my ID.

Name of bank

Branch name Branch code - -

Account number Type of account Cheque ☐ Transmission ☐ Savings ☐

Account holder name

Signature of account holder

Please do not sign an incomplete application form

Signature of principal member

Please do not sign an incomplete application form

Please note: If you are using someone else's bank account, the account holder must sign above to confirm this.

5. Contact information for future correspondence

Postal address

☐ PO Box ☐ Private Bag Box number

☐ Suite ☐ PostNet Suite Number

Suburb

City Postal code

Telephone

Email

6. Declaration

When you sign this application, you confirm that all the information provided is correct.

Principal member signature

Please do not sign an incomplete application form

Date