

Transfer from active to retiree status



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

This form is for principal members who move onto retiree status, to make contributions or payments directly to SAB Medical Aid.

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.

How to complete this form

1. Please use one letter per block, complete with black ink and print clearly.
2. Please complete this form and return it to your Human Resources department.
3. To avoid administration delays, please make sure this application is completed in full.
4. Please contact the SAB Medical Aid Customer Care Centre on **0860 002 133** for any queries.

1. Main applicant information

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2. Banking details for your monthly contributions

You need to submit the following with this form:

- Copy of the account holder's ID
- Bank statement or letter of confirmation from the bank not older than three months. Only an original bank statement will be accepted.

These details apply when you pay directly towards your total contribution. We cannot accept credit card details. You can 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						Branch code			-			-				
Account number										Type of account	Cheque	☐	Transmission	☐	Savings	☐
Account holder																
Signature of account holder																

I, hereby give Discovery Health and/or SAB Medical Aid permission to charge my bank account for my contributions to SAB Medical Aid.

3. Banking details for reimbursement of your claims

You need to submit the following with this form:

- Copy of the account holder's ID
- Bank statement or letter of confirmation from the bank not older than three months. Only an original bank statement will be accepted.

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

Bank name																
Branch name						Branch code			-			-				
Account number										Type of account	Cheque	☐	Transmission	☐	Savings	☐
Account holder																
Signature of account holder																

4. Your legal declaration

It is my sole responsibility as a member, to make sure SAB Medical Aid receives the monthly contributions. 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 SAB Medical Aid in writing of any change in details, that may occur between the date of this application and the activation of my membership with SAB Medical Aid.

Signed at (town or city)		on	D	D	M	M	Y	Y	Y	Y
Signature of applicant										

Please do not sign an incomplete application form