Contact centre: 0860 002 101
General enquiries: service@alliancemidmed.co.za
Authorisation enquiries: auths@alliancemidmed.co.za
Clinical enquiries: clinical@alliancemidmed.co.za
www.alliancemidmed.co.za

ALLIANCE-MIDMED MEDICAL SCHEME

MEMBERSHIP CHANGE ADVICE

Principal member number	Principal member initals	Principal member surname	Effective change date
			D D M M Y Y

SECTION 1. SALARY BRACKET CHANGE

Please change my salary bracket to	

SECTION 2. PERSONAL DETAILS CHANGE

2.1 ADDRESS AND COMMUNICATIONS

Postal address		Physical address	
Home telephone		Work telephone	
Telefax			
Email			

2.2 BANKING DETAILS

☐ USE THIS ACCOUNT FOR ALL TRANSACTIONS

☐ USE THIS ACCOUNT FOR COLLECTIONS ONLY

☐ USE THIS ACCOUNT FOR CLAIMS AND SAVING REFUNDS ONLY

(Please submit original proof of banking details for debit order, if employer is responsible for paying contributions.)

Name of account holder		Name of account holder	
Bank name		Bank name	
Bank account number		Bank account number	
Branch code		Branch code	
Type of account	Cheque Transmission Savings	Type of account	Cheque Transmission Savings

1. I authorise Alliance-MidMed Medical Scheme (the Scheme) to debit this account with the amount due under contract in accordance with the Scheme's debit order system, **and/or**
2. I understand that by providing these details I authorise the Scheme to pay claim reimbursements directly into this bank account, **and**
3. I will not hold the Scheme responsible for paying contributions.

Signature of account holder _____ Date D D M M Y Y Y Y

SECTION 3. DEPENDANT CHANGE

(All dependant additions must have a Dependant Add application form submitted with this Change Advice, for consideration by the Underwriting department. Newborn babies of the principal dependant, are exempt from the Dependant Add application form and exempt from underwriting.)

First name and surname of dependant	ID number (Please provide copy)	Sex		Relationship	On	Off
		M	F		On	Off
		M	F		On	Off
		M	F		On	Off
		M	F		On	Off

SECTION 4.

I warrant that all particulars relevant to this change advice are true and correct and understand that any false statement will render my membership null and void.

Principal member signature _____ Date D D M M Y Y Y Y

SECTION 5. MEMBER CHANGES

Transfer within company	Suspend	Continuation	Termination	Deceased	Retired	Retrenched

If transferring, please supply:

New company number	
New company name	
New employee name	
If terminating, please supply reason	

Do you wish your savings to be transferred to your new Medical Aid?	Y	N

If yes, please supply details:

New medical aid scheme	
New membership number	

If no, please note the following:

1. The payment will be processed five months after termination of your membership. The reason for this is that claims could be payable for up to four months after the date on which you recieved a medical service.
2. As prescribed by law, Alliance-MidMed must pay your positive savings balance to your new Scheme if your new benefit option ahs a savings plan.
3. If you do not join another medical scheme or join a medical scheme without a savings plan, we will pay your positive savings balance to your bank account.

   To do so, you are required to do the following:

   - complete an affidavit in the block provided below, declaring that you are not joining a scheme with a savings plan
   - attach a copy of your identity document
   - attach a letter from your bank, confirming your bank account details.

Please ensure that we have the correct account details and that your account is current in the fifth month after your membership termination. Your positive savings balance will be refunded into this account without prior notice and we will not accept responsibility for payments into incorrect accounts. Kindly note that we may not pay the funds into the account of the third party.

AFFIDAVIT

Name and surname	
ID number	

State under oath/solemnly declares that:

Signature _____ Date D D M M Y Y Y Y

I certify that the above statement was taken by me and the deponent has acknowledged that he/she knows and understands the contents of the statement, his/her signature was placed hereon in my presence _____ on _____ (date) at _____ (time).

COMMISSIONER OF OATH

Name and surname	
Business address	

SECTION 6. EMPLOYER VERIFICATION

I/We are not aware of any fact other than those stated which should be made known to the Scheme and do hereby certify the applicant to be a permanent staff member.

Signature _____ Date D D M M Y Y Y Y