SAMWUMED

Real Heritage. Real People. Real Health Care.

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APPLICATION TO CHANGE BENEFIT OPTIONS PM003

PLEASE USE BLACK OR BLUE INK WHEN COMPLETING THIS FORM. WHERE APPROPRIATE MARK YOUR SELECTION WITH AN "X"

A. PERSONAL PARTICULARS – COMPLETE BLOCKS FROM LEFT TO RIGHT, ONE LETTER PER BLOCK

Title (Dr, Mr, Mrs or Miss) Initials Membership No

Surname

First name(s)

Date of birth D D M M Y Y Y Y Identity/passport number

Marital status ☐ Married ☐ Single ☐ Divorced ☐ Widow/er Gender M F

Postal address

Postal code

Telephone (H) (W)

Fax Cellphone

E-mail address

B. I HEREBY WISH TO CHANGE BENEFIT OPTIONS AS STATED BELOW

CURRENT OPTION NEW OPTION

C. TO BE COMPLETED BY EMPLOYER

NAME OF EMPLOYER

Staff Number

The above detail have been noted and approved. Contributions will be adjusted as per schemes rules with effect from: 0 1 0 1 2 0 Y Y

EMPLOYER OFFICIAL STAMP

Signature of member _____ Date of application D D M M Y Y Y Y