# MEDSHIELD
## medical scheme

# TERMINATION REQUEST

**Please note: Should your termination request reach the Scheme after the 7th business day of the month, your termination will only be effective at the end of the following month.**

Principal Member Number:

Principal Member Name/s:

Principal Member Surname:

Termination Effective Date:

| SECTION A | COMPANY APPROVAL (Please note that Medshield cannot process your termination if this section has not been fully completed by your HR Representative/Employer.) |
|---|---|

Name of Employer:

Email Address:

Telephone No.:

Termination Effective Date:

### COMPANY STAMP

Tick this box if no Company Stamp is available ☐

By selecting this box you confirm that the Employer has granted approval ☐

HR Representative's Signature: _____

## MY REASON FOR TERMINATION RELATES TO:

Mark with an X where necessary.

| | | | |
|---|---|---|---|
| Inadequate Benefits: | ☐ | Resigned From Employer: | ☐ |
| Increased Contributions: | ☐ | Retirement: | ☐ |
| Emigrating: | ☐ | Retrenchment: | ☐ |
| Broker Advice: | ☐ | Condition of Employment: | ☐ |
| Affordability: | ☐ | Company Liquidation: | ☐ |
| Joining Another Scheme: | ☐ | | |

*Scheme you are joining* _____

| | | | |
|---|---|---|---|
| Hospital Network: | ☐ | Contact Centre Service: | ☐ |
| FP Network: | ☐ | Credit Control Service: | ☐ |
| Claims Administration - Bad Service: | ☐ | Membership Service: | ☐ |
| Underwriting: | ☐ | Deceased: | ☐ |
| Midyear Option Change: | ☐ | Loyalty Programme: | ☐ |

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Medshield is an Authorised Financial Services Provider (FSP 51381)

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In order for Medshield to improve on our service delivery, please give a brief description of the issue you experienced:

_____

_____

_____

**Please email the completed form to creditcontrol@medshield.co.za alternatively, fax the attached form back to 010 597 4709.**

Principal Member Signature: _____     Date: