MEDSHIELD
medical scheme

REQUEST FOR SAVINGS REFUND

Please complete all the relevant sections of this form in BLOCK LETTERS.

The completed form, together with any relevant documentation, must be emailed to savings@medshield.co.za

Membership Number:

SECTION A — TO BE COMPLETED BY THE PRINCIPAL MEMBER OF THE SCHEME

Principal Member Name:

Principal Member Surname:

Principal Member ID Number:

Principal Member Cell Number:

Principal Member Email Address:

SECTION B — TO BE COMPLETED BY THE PRINCIPAL MEMBER OF THE SCHEME

Please note: Savings balance due will only be refunded in the 5th month after your termination date, or change in benefit option to a non-savings plan for active members.

Please enter the savings amount due as reflected on your last statement received.

Last Statement Date: D D M M Y Y Y Y

Savings Balance: R

SECTION C — TO BE COMPLETED BY THE PRINCIPAL MEMBER OF THE SCHEME

Are you currently on Medical Aid? Y N

If yes, please provide new Medical Aid Name:

Membership Number:

Does your current Medical Aid have Savings? Y N

If yes, please provide new medical aid's banking details, if no, please provide your banking details, supported by the latest stamped confirmation of bank account letter (Name and account holder and the date when the account was opened must be clear on the letter) and a copy of the Principal Member's identity document and the account holder's identity document, if they differ:

Bank Account Holder:

Bank Name:

Branch Name:

Branch Code:

Type of Account: (Mark with an X) Current Transmission Savings

Bank Account Number:

SECTION D MEMBER DECLARATION

I, _____ (Principal Member's full name) the undersigned, upon receiving my signed form, hereby give Medshield Medical Scheme the authority to refund my savings balance on my request and acknowledge that:

Details contained herein are true and accurate.

- I hereby authorise the Scheme, or any of its nominated representatives, to verify the bank details and identity document(s);
- I am aware that this form must be received by Medshield Medical Scheme before the refund is authorised;
- I will be liable for any refund amount refunded to me in error.

_____

Principal Member Signature:

Date: | D | D | M | M | Y | Y | Y | Y |