SIZWE HOSMED
MEDICAL SCHEME
Your choice for quality care

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Midrand
1696

MEMBERSHIP UPDATE FORM

PLEASE COMPLETE APPROPRIATELY ALL THE SECTIONS BELOW IN FULL AND PROVIDE SUPPORTING DOCUMENTATION WHERE POSSIBLE

SECTION A: MAIN MEMBER INFORMATION

Membership No.		ID No.	
Members Name		Title	
Employer Name		Employee No.	
Preferred Provider Name			
Tax No. (SARS)		Gender	
Practice Number & Area			
Race (please tick)	African	Coloured	Indian/Asian	White

SECTION B: CHANGES TO CONTACT INFORMATION

Cell No.		Work Tel.	
Home Tel. No.		E-mail	

Preferred method of communication (please tick) Email ☐ SMS ☐ Post ☐

New Postal Address			
		Postal Code	
New Residential Address			
		Postal Code	

SECTION C: DEPENDANT DETAIL UPDATE ONLY (NOT FOR ADDITION)

	Dependant 1	Dependant 2	Dependant 3	Dependant 4	Dependant 5
Name and Surname of dependant					
ID number (compulsory)					
Sex (M/F)					
Race (African, Coloured, Indian/ Asian, White)					
Address, if different from member					
Cell no.					
Notes for change to be made					

SECTION D: TERMINATION OF DEPENDANTS

	Name	Surname	Date of Birth	Date of Termination	Reason
1.					
2.					
3.					

SECTION E: OTHER REQUESTS (example: change of surname, rectify personal details not listed above, etc.)

1.					
2.					

Please ensure relevant documentation is attached to the update form to avoid any delay in processing.
I declare that the information given is true and correct and I am aware that any false statement will render my membership of the Scheme null and void.

Signature of Member | HR Stamp | HR Details/Signature | Date

16502|SH | CP | 220926