SIZWE HOSMED
MEDICAL SCHEME
Your choice for quality care

0860 100 871
086 608 0771
queries@sizwehosmed.co.za
23 West Street,
Houghton Estate,
Johannesburg,
2198

MEDICAL SAVINGS ACCOUNT (MSA) REFUND

Members who have terminated their Scheme membership or changed to an option that does not offer a medical savings account (MSA)

Please note the following;

- In terms of Section 10 of the Medical Schemes Act (MSA) 131 of 1998, If you terminate your membership and join another medical scheme with a medical savings account, the full amount available in your medical savings account will be transferred to your new medical scheme.
- If you do not join another medical scheme or remain active on a non-savings option, or if you have joined another medical scheme on a non-savings option, the full balance in your medical savings account will be paid to you.
- This will be processed after a 4-month waiting period, payable in the 5th month, to allow for any outstanding or late claims to be processed before savings are refunded.
- Medical savings account refunds are subject to availability of funds after all debt is settled on claims and contributions.

In order for the Scheme to process and allocate any balance due in accordance with applicable regulatory requirements, we kindly request that you complete and return the below form and all supporting documents to savings@sizwehosmed.co.za

MEMBER DETAILS

Name	
Surname	

ID Number													

Sizwe Hosmed Membership Number	

Contact Number Cell		Contact Number Work	
Email Address			

MEDICAL SCHEME DETAILS

OLD MEDICAL AID DETAILS		NEW MEDICAL AID DETAILS	
Scheme Name	Sizwe Hosmed	Scheme Name	
Option Name		Option Name	
Membership Number		New Membership Number	
		Does your current medical aid have savings (Yes / No)	

PAYMENT INSTRUCTION BANKING DETAILS

I confirm that the following statement is correct (please mark X in the applicable box)

	I have joined a medical scheme and option that has a medical savings account.
	I have joined a medical scheme and option that does not have a medical savings account
	I did not join another medical scheme.

Account Holder						
Account Number						
Account Type (Indicate X)	Current		Savings		Transmission	
Name of Bank						
Branch						
Branch Code						

I declare that the information provided is true and correct to the best of my knowledge. I understand that any false information or outstanding documents may delay or invalidate the refund process.

_____

Signature of Account Holder

Date: | | | | | | | | |

Supporting Documents List	Check
Completed Medical Savings Account Refund Form	
Copy of the principal member's ID	
Copy of new membership certificate from new medical aid scheme	
Proof of banking details (A bank confirmation letter stamped or digital, or a stamped and signed bank statement not older than 90 days)	
Third Party bank account holder If Required: • A signed letter of authority from the principal member authorising the use of the third-party bank account. • A signed letter from the account holder accepting responsibility for the account and authorising the Scheme to transact against the account where applicable. • Copy of account holder ID, If account holder is a company or trust, the company registration documents, or trust deed is required, Where a legal representative acts on behalf of the member, a valid Power of Attorney or other legal mandate (court order) is required • Proof of banking details (A bank confirmation letter stamped or digital, or a stamped and signed bank statement not older than 90 days)	

Fund Declaration:

As Sizwe Hosmed Medical Scheme we are strongly committed to protecting your personal data. We are required by POPIA to explain why and how we collect, use, and disclose your personal information, which may include health and financial information. Sizwe Hosmed Medical Scheme and its administrator (3Sixty Health (Pty) Ltd) will keep your information supplied to us in this application confidential. Acceptance of these terms and conditions is a requirement for activation and servicing of your medical scheme membership. You give us consent to process your personal information for the following purposes:

a. Administration of your health care option;
b. Provision of managed care services to you;
c. Providing relevant information to a contracted third party;
d. To profile and analyse risk;
e. For research purposes and;
f. To comply with legislation.

Please note that we will only share your information with a third party if you have granted us your consent for the disclosure of the information to such third party or if a contractual relationship exists in terms of which we are obliged to provide your information to such third party. We may amend this notice from time to time, please check our website to inform yourself of any changes.