ESKOM OPTION SELECTION FORM

SIZWE MEDICAL FUND

1. Only complete this form if you want to change from your current option. Please submit it immediately to your employer to ensure the form reaches Sizwe by 10 December.
2. Direct-paying members should submit this form to their nearest Sizwe branch.

SECTION 1 TO BE COMPLETED BY MEMBER

I, (name of member)

Membership Number: wish to change to the following option

(please tick appropriate box):

Medical Fund Options

☐ Hospital Care ☐ Savings Care ☐ Primary Care ☐ Affordable Care ☐ Full Benefit Care

PREFERRED METHOD OF COMMUNICATION: SMS ☐ Email ☐ Post ☐

Please read the following instructions before submitting your option change form.

Group members:
Return your completed option change form to your employer's HR or Payroll Office. The HR or Payroll Office must sign and stamp the form and return it to the Sizwe branch that administers your company's membership.

Note: Option change forms for members within a company are subject to approval by the employer. Only forms that are signed and stamped by your company's HR/Payroll Office will be accepted and processed.

Direct-paying members:
Return your completed option change form to the Sizwe branch that administers your membership. (Please see relevant contact details on the back of this form.)

Pensioners:
Return your completed option change form to your pension administrator or the nearest Sizwe branch. (Please see relevant contact details on the back of this form.)

Note: The pension administrator must sign and stamp the form and return it to the Sizwe branch that administers your membership. Option change forms that are not signed and stamped by your pension administrator will not be accepted. The option change form must be submitted with your ID and proof of income, if proof is not received the income will be based on the highest category of the chosen option.

DECLARATION AND ACCEPTANCE OF RESPONSIBILITY

I understand that I must give written notice by 10 December of my intention to transfer to a new benefit option in the following year, which becomes effective on the first day of January following submission of my option selection.
I accept that I can only change options once a year and will remain on this option until 31 December of that year.
I understand and accept that the option change might affect my current benefits and I take responsibility for the consequences of any benefit changes as a result of option changes. I understand that I am responsibile for payment in full of the monthly contributions on my new option.

Member's signature Date:

SECTION 2 | TO BE COMPLETED BY EMPLOYER

Name of employer

Salary R:

Income category: Please refer to the Benefit Guide

The above details have been noted and approved. Contributions will be appropriately adjusted in terms of the rules.

Employer's signature:

Designation:

Date:

COMPANY STAMP

TO BE COMPLETED BY DIRECT-PAYING MEMBERS

Name of Pension Fund (where applicable)

Salary R:

Income category: Please refer to the Benefit Guide

I declare that the above details are correct and attach proof of income (eg, salary slip, tax return, SARS ITA34 auditor's certificate).

Member's signature:

Date:

VERY IMPORTANT: Option changes will not be accepted after the closing date of 14 December.

PLEASE NOTE:

1. You are allowed to move from one option to another once a year – i.e on 1 January each year.

This form and a copy of your ID must be returned to your employer immediately so that s/he can forward them to the nearest Sizwe branch by no later than 14 December. Direct-paying members can fax or email forms directly to their nearest Sizwe branch:

JOHANNESBURG: 011 353-0267
CAPE TOWN: 021 418-1400
EMALAHLENI (WITBANK): 013 690-3187
PORT ELIZABETH: 041 503-1060
DURBAN: 031 304-4839
WELKOM: 057 900-2285

Email: membership@sizwemedfund.co.za