TFG MEDICAL AID SCHEME

Administered by Discovery Health

Contact details
Tel: 0860 123 077 • PO Box 652509, Benmore 2010 • www.tfgmedicalaidscheme.co.za

Benefit Plan Change Form

Who we are

TFG Medical Aid Scheme (referred to as 'the Scheme'), registration number 1578, is a not-for-profit organisation, registered with the Council for Medical Schemes. Discovery Health (Pty) Ltd (referred to as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). We take care of the administration of your membership for the Scheme.

I, _____ hereby apply for a Benefit Plan change and wish to change to:

TFG Health ☐

TFG Health Plus ☐

All requests must be returned to tfgmedicalaid@tfg.co.za before 17 December 2021

I am aware my request will be implemented in the month following the date my request is sent to the Fuse and that I will be required to remain on the current plan for the remainder of 2022, until such time as I am able to submit another Benefit Plan change form at the end of the year.

1. Member details

Title _____ Surname _____

First name/s _____ Sex M ☐ F ☐

Date of birth D D M M Y Y Y Y

ID Number _____ Marital status _____

Membership number _____ Cellphone _____

Telephone (H) _____ (W) _____

Email _____ Home ☐ Work ☐

Physical Address _____

_____

_____ Code _____

Postal Address _____

_____

_____ Code _____

Employee number (if applicable) _____

TFGBPC001

Please note that this form expires on 31/03/2023. Up to date forms are available on www.tfgmedicalaidscheme.co.za.
Alternatively members can phone 0860 123 077 and health professionals can phone 0860 44 55 66.

2. Benefit Plan Selection

Please complete this if you have selected TFG Health as your chosen Benefit Plan. Please select a GP on the Scheme GP Network for yourself as well as each of your dependants.

- If you live far away from where you work or you often need to work in different towns or provinces, you may need a second GP.

	Name	GP Name	Practice Number (Required)	*Second GP Name	Practice Number (Required)
Main member					
Spouse or partner					
Dependent 1					
Dependent 2					
Dependent 3					

3. Return details

Please complete this form and send it to tfgmedicalaid@tfg.co.za.

I hereby sign and acknowledge that this Benefit Plan change is taking effect on the date as set out in this form and that Benefit Plan changes will not be applied backdated. Any authorisations for procedures and treatment will be subject to the benefits available on the new Benefit Plan as per this application submitted to the Scheme. I have read the Scheme's Benefit Plan brochures and available communications on the Scheme website at www.tfgmedicalaidscheme.co.za and familiarised myself with the benefits of my chosen Benefit Plan, subject to the registered Rules of the Scheme which is also available on the Scheme website, and accept and acknowledge that I was not influenced or given advice in changing Benefit Plan by the Administrator, nor my employer, but received sound advice from my personal broker and/or am exercising this change by my own informed choice. I understand that the reduction in contributions will only be prospective and will not be backdated. I further understand that this option to change Benefit Plans is once-off and the next opportunity to change will be at the end of the year.

Should you be unable to return this form by printing, signing and scanning it in, you may opt to inform us of your Benefit Plan change and your chosen GP as set out in this document. You will then need to send us an email with the information set out in this document included in the electronic mail sent through and/or using this editable document to complete all required fields, returning the form to us with an electronic signature inserted below.

4. Electronic return signature

Full name and surname

Title

Contact details

Email address

Member's signature

Date D D - M M - Y Y Y Y

Please do not sign an incomplete form
I confirm the information is accurate and complete

In the event that you will be sending a Benefit Plan change to us per electronic mail, you will need to include the following in your email to validate your choice:

I (full name and surname)

ID Number (ID NO/PASSPORT NO) confirm that I am unable to sign the Benefit Plan change form, due to spatial distancing measures in place during the COVID-19 pandemic.

TFGBPC001

I acknowledge and confirm the following:

- I have read, understood and agree to the terms and conditions of the Benefit Plan Change Form.
- I authorise Discovery to accept this email with this document included and completed electronically as my confirmation, consent and signature for this application.

I hereby indemnify Discovery, TFGMAS, its employees and representatives against any loss or damage I may suffer, which may arise directly or indirectly from my decision.