



MEDICAL AID SCHEME



Administered by

Discovery Health

Contact details

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

Transfer from active to retiree status

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.

How to complete this form

- 1. Please use one letter per block, complete in black ink and print clearly.
2. To avoid administration delays, please ensure this application is completed in full.
3. To be completed and returned to your Human Resources department.
4. Please call TFG Medical Aid Scheme on 0860 123 077 for any queries.

1. Member information (main applicant)

Form fields for member information: Membership number (compulsory), Employee number (compulsory), Title, Initials, Surname, First name(s), Preferred name, Sex (M/F), Date of birth, Marital status (Married/Single/Divorced/Windowed), Date of marriage, Previous or maiden name, ID or passport number, Country of issue, Telephone (H/W), Fax, Cellphone, Email, Postal address, Residential address, Code.

2. Banking details for your monthly contributions

What you must do

Submit the following with this form: A copy of your ID and a bank statement/letter of confirmation from the bank.

These details apply when you pay directly towards your total contribution. Please note that we cannot accept credit card details. You may only use a South African bank account. The first deduction will take place at the beginning of the month following the start date as a retiree member.

Bank name	<input type="text"/>	Branch name	<input type="text"/>
Account type	Current <input type="checkbox"/>	Transmission <input type="checkbox"/>	Savings <input type="checkbox"/>
		Branch code	<input type="text"/>
Name of account holder	<input type="text"/>		
Account Number	<input type="text"/>		
Signature of account holder	<input type="text"/>		

I, , hereby give

Discovery Health (Pty) Ltd and/or TFG Medical Aid Scheme permission to charge my bank account for my contributions to TFG Medical Aid Scheme.

3. Banking details for reimbursement of your claims

What you must do

Submit the following with this form: A copy of your ID and a bank statement or letter of confirmation from the bank.

Same as above? Yes No (if "No", please complete below)

Bank name	<input type="text"/>	Branch name	<input type="text"/>
Account type	Current <input type="checkbox"/>	Transmission <input type="checkbox"/>	Savings <input type="checkbox"/>
		Branch code	<input type="text"/> - <input type="text"/> - <input type="text"/>
Name of account holder	<input type="text"/>		
Account number	<input type="text"/>		
Signature of account holder	<input type="text"/>		

4. Your legal declaration

It is my sole responsibility as a member to make sure TFG Medical Aid Scheme receives the monthly contributions. If contributions are outstanding for two months in a row, my membership will be cancelled in the third month. Short payment or non-payment of any of my contributions will result in suspension of my claims.

I confirm the content of this application is true and complete.

I agree to advise TFG Medical Aid Scheme in writing of any change in details that may occur between the date of this application form and the activation of my membership with TFG Medical Aid Scheme.

Signed at Date

Signature of applicant

Please do not sign an incomplete application form

5. Your employment details

If your employer is paying your full contribution or a part of it, please complete this section:

Name of employer		<input type="text"/>																															
Employer / billing number		<input type="text"/>								<input type="text"/>								<input type="text"/>															
Employee number		<input type="text"/>								<input type="text"/>								Date of employment															
		<input type="text"/>								<input type="text"/>								<input type="text"/>								<input type="text"/>							
1. Employer contact person												2. Employer contact person																					
Telephone		<input type="text"/>				<input type="text"/>				<input type="text"/>				<input type="text"/>				<input type="text"/>				<input type="text"/>											
Email												Email																					
Branch name												Branch name																					
Department name												Department name																					
Date of promotion (if applicable)		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>							
		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>							

Please ensure your employer completes this warranty.