Postal address PO Box 16148, Doornfontein, 2028
Share Call 0860 00 0048
Fax 086 608 0771
E-mail newapp@hosmed.co.za

hosmed medical scheme care for life

NEW MEMBERSHIP APPLICATION FORM

PLEASE PRINT IN CAPITAL LETTERS. USE A BLACK PEN ONLY, PLEASE MARK APPROPRIATE CHOICE USING A CROSS (x)

Membership Number	
Department	
Tel	
Company name	
Broker	

Broker Stamp

SECTION A: MEMBER DETAILS

Title: Mr/Mrs/Miss		Initials		First name	
Surname				Identity no.	
Tel. no. (h)		(w)		(Cell)	
Email					
Residential address					
				Postal code	
Postal address					
				Postal code	

SECTION B: HOSMED MEMBERSHIP DETAILS

Preferred option						Employee no.	
Join date		Total contribution	R			Gross monthly salary	R

SECTION C: PARTICULARS OF DEPENDANTS

Dependants	Name	Surname	Gender	ID number	Relationship (compulsory)
Spouse					
Child 1					
Child 2					
Child 3					
Child 4					

SECTION D: BANK DETAILS (FOR CLAIMS REFUND)

Account holder							
Account number		Account type (please mark appropriate)		Current		Transmission	Savings
Name of bank			Branch code				

I acknowledge that:

(a) I am aware that, once I have decided to move to another medical aid scheme – for which provision is made by my employer – I will not be allowed to move to another scheme during the next 12 months.

(b) The onus rests with me to ensure that my application is submitted to my Support Services Division.

(c) I must register my chronic medication with Hosmed.

Signature of member | Employer Name | Employer Signature | Employer Stamp | Date