

MEMBERSHIP TERMINATION REQUEST

PLEASE COMPLETE FORM IN BLOCK LETTERS

1. PRINCIPAL MEMBER'S DETAILS

Membership number	<input type="text"/>		
Title	<input type="text"/>	Initials	<input type="text"/>
Full name and surname	<input type="text"/>		
Contact number	<input type="text"/>	ID/Passport number	<input type="text"/>
Email address	<input type="text"/>		
Employee number	<input type="text"/>		
Termination effective from	<input type="text" value="DD/MM/YYYY"/>		

2. REASON FOR TERMINATION

Please tick the applicable box/es below.

- | | |
|-----------------------------------------------|----------------------------------------------------------------------|
| <input type="checkbox"/> Change of employment | <input type="checkbox"/> Financial reasons |
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Death (please supply the death certificate) |
| <input type="checkbox"/> Divorced/Separated | <input type="checkbox"/> Transfer to a new medical scheme |
| <input type="checkbox"/> Dismissed | <input type="checkbox"/> Left company (no longer employed) |
| <input type="checkbox"/> Retirement | <input type="checkbox"/> Other |
| <input type="checkbox"/> Retrenchment | |

If 'Other', please specify:

3. TERMINATION OF DEPENDANTS' MEMBERSHIP

Please provide details of the applicable dependant(s) whose membership will be terminated.

Dependant first name	Dependant surname	Gender	Date of birth	Identity number	Relationship to principal member e.g. wife, son	Termination date
		Male Female	DD/MM/YYYY			DD/MM/YYYY
		Male Female	DD/MM/YYYY			DD/MM/YYYY
		Male Female	DD/MM/YYYY			DD/MM/YYYY
		Male Female	DD/MM/YYYY			DD/MM/YYYY
		Male Female	DD/MM/YYYY			DD/MM/YYYY

4. DECLARATION

I, the undersigned, declare that I have carefully read this application form, completed it in full, and confirm that all the information provided herein to be true and correct to the best of my knowledge.

Signature of principal member (employee)	<input type="text"/>	Date	<input type="text" value="DD/MM/YYYY"/>
------------------------------------------	----------------------	------	-----------------------------------------

Signed on behalf of the employer	<input type="text"/>	Date	<input type="text" value="DD/MM/YYYY"/>
Full name of signatory	<input type="text"/>		
Designation	<input type="text"/>		
Employer stamp	<input type="text"/>		

DISCLAIMER:

PG Group Medical Scheme reserves the right to list members who, in the opinion of the Scheme's Administrator, Momentum Health Solutions (Pty) Ltd Fraud and Ethics Committee, have behaved unethically towards the Scheme, abused their benefits, perpetrated fraud or colluded with others to perpetrate fraud against the Scheme, on the TransUnion Credit Bureau. This information may be viewed by all medical schemes that participate in the Board of Healthcare Funders' (BHF) Forensic Management Unit.



02/2023

Administered by Momentum Health Solutions (Pty) Ltd

PO Box 2070, Bellville 7535
Tel: 0860 005 037
General fax: 0861 647 775
Membership fax: 0861 222 664
Email: membership@pggmeds.co.za
Website: www.pggmeds.co.za