REQUEST FOR SAVINGS REFUND

Please complete all the relevant sections of this form in BLOCK LETTERS.

MEMBERSHIP NUMBER

SECTION 1 TO BE COMPLETED BY PRINCIPAL MEMBER OF THE SCHEME

MEMBER SURNAME

MEMBER FIRST NAMES

ID NO.

CONTACT NO.

SECTION 2 SAVINGS DETAILS

Please note: Savings balance due will only be refunded in the 5th month after your termination date from Medshield Medical Scheme.
Please enter savings amount as it reflects on your last statement received.

LAST STATEMENT DATE

SAVINGS BALANCE: R

SECTION 3 MEDICAL AID AND BANK DETAILS

ARE YOU CURRENTLY ON MEDICAL AID? YES NO

IF YES, PLEASE PROVIDE NEW MEDICAL AID NAME AND

MEDICAL AID NUMBER

DOES YOUR CURRENT MEDICAL AID HAVE SAVINGS? YES NO

IF YES, PLEASE PROVIDE NEW MEDICAL AID'S BANKING DETAILS, IF NO, PLEASE PROVIDE YOUR BANKING DETAILS:

ACCOUNT HOLDER

BANK NAME

BRANCH

BRANCH CODE

ACCOUNT NUMBER

TYPE OF ACCOUNT Current | Transmission | Savings

IF YOU PROVIDE YOUR BANK DETAILS PLEASE ALSO SEND THE FOLLOWING DOCUMENTS

- Copy of your ID Document
- Copy of your stamped Bank statement (Name and account number must be clear on the statement)

SECTION 4 MEMBER DECLARATION

I, _____ (Principal Member's full name) the undersigned, upon receiving my signed form, hereby give Medshield Medical Scheme the authority to refund my savings balance on my request and acknowledge that:

- Details contained herein are true and accurate;
- I am aware that this form must be received by Medshield Medical Scheme before the refund will be actioned.

_____
Principal Member Signature

DATE D D M M Y Y Y Y

Completed form to be faxed to 010 597 4712 or e-mailed to savings@medshield.co.za