transmed
MEDICAL FUND

Contact details:
Customer service department 0800 450 010

Email:
membership@transmed.co.za

MEMBERSHIP NUMBER

APPLICATION FOR CONTINUATION OF MEMBERSHIP FOR PENSIONERS

PLEASE COMPLETE THE FORM IN BLOCK LETTERS.
It is important that all sections of this form be completed in full. Failing to do so will cause a delay in the processing of the application. Once the form has been completed, it should be returned to membership@transmed.co.za. You may also fax it to 011 381 2490 or post it to Transmed Membership, PO Box 2269, Bellville 7535. Only employees who are members of Transmed Medical Fund at the time of retirement are eligible to continue as pensioner members. If you require assistance in completing this form, please call 0800 450 010.

1. APPLICANT'S INFORMATION

Income tax reference number

Identity/Passport number (copy of identity document required)

Date of birth D D M M Y Y Y Y Title

Surname

First names

Telephone (W) (H)

Cell number

Email address

Postal address

Code

Residential address

Code

2. BANK DETAILS FOR DIRECT DEPOSITS OR REFUNDS

Please complete this section in full and attach a copy of your ID and a bank statement or stamped letter from your bank (not older than three months). Banking details are required for the purpose of making refunds due to members and for the collection of membership contributions.

Account holder

Account number

Name of bank

Branch name Branch code

Account type ☐ Current/Cheque ☐ Savings ☐ Transmission

3. RETIREMENT INFORMATION

Retirement date D D M M Y Y Y Y (letter of retirement must accompany this form)

Entitled to the monthly subsidy ☐ Yes ☐ No (letter confirming entitlement to monthly subsidy must accompany this form)

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4. PLAN SELECTION

Please select your plan by ticking the relevant block:

☐ Link plan ☐ Select plan ☐ Prime plan

5. AFFIDAVIT – DETAILS OF MONTHLY INCOME

I declare that my monthly income is R | | | | | | | | and consists of the following:

☐ Monthly pension ☐ Annuities ☐ Investments ☐ Other (please specify): _____

I, _____ , confirm that all of the information is true in every respect.
I understand and agree that the consequence of submitting inaccurate information could result in the:

- forfeiture of all benefits of the Fund
- refunding in full all amounts for benefits/services paid on my behalf by Transmed
- waiving of my right to claim a refund for any contributions paid by me to Transmed.

Signed at _____ on | D | D | M | M | Y | Y | Y | Y |

		D D M M Y Y Y Y
COMMISSIONER OF OATHS	SIGNATURE OF MEMBER	DATE

6. CONSENT FOR TRANSMED MEDICAL FUND TO PROCESS PERSONAL INFORMATION

Transmed Medical Fund and the Administrator, Momentum Health Solutions, a division of Momentum Metropolitan Holdings, are committed to maintaining the confidentiality of your personal information and complying with the Protection of Personal Information Act, 2013 when processing your personal information. Your personal information will be processed for the purpose of the Medical Schemes Act, 131 of 1998.

We request your consent to process your personal information and obtain your personal information from any other person for the purposes set out in this section. While your consent is voluntary, it is a requirement for your membership of Transmed Medical Fund. If you fail to provide the personal information required or if you are not willing to agree to the processing of your personal information, Transmed Medical Fund will not be able to administer or offer you membership of the Fund. Please read the statements below and sign your acceptance thereof.

1. That you authorise, and give consent to, Transmed Medical Fund and the Administrator to collect, store, collate, process, share and further process your personal information, including health information, and that of your dependants, for purposes of your membership of Transmed Medical Fund, risk profiling, management, administration of your membership and as set out in this section.
2. If you have consented to the disclosure of your personal information, Transmed Medical Fund or the Administrator may provide your personal information to any natural or juristic person (which could include a company, corporation, state, or agency of a state, association, trust or partnership) or if a contractual relationship exists between Transmed Medical Fund or the Administrator that requires them to do so.
3. You acknowledge the need to give Transmed Medical Fund and the Administrator all information and evidence they may require from time to time. You authorise Transmed Medical Fund and the Administrator to obtain from any person, including any medical doctor or other healthcare provider who has attended to you or your dependants in the past, or who will attend to you or your dependants in the future, any information Transmed Medical Fund may require concerning you or any of your dependants in assessing any risk or claim in relation to this application, your membership of Transmed Medical Fund and risk profiling or management. You consent to that person providing, and instruct that person to provide, Transmed Medical Fund and the Administrator with this information on request. You waive the provisions of any law or regulation that restricts the disclosure of this information.

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6. CONSENT FOR TRANSMED MEDICAL FUND TO PROCESS PERSONAL INFORMATION (CONTINUED)

4. You have the right to withdraw your consent to have your personal information processed, provided that the lawfulness of the processing of your personal information before your withdrawal will not be affected.
5. You have the right to object, on reasonable grounds relating to your particular situation, to the processing of your personal information, unless processing is required by law.
6. You have the right to request your personal information that is in the possession of Transmed Medical Fund and the Administrator, provided that you furnish adequate identification.
7. You have the right to request Transmed Medical Fund and the Administrator, where necessary, to correct or delete your personal information that is inaccurate, irrelevant, excessive, outdated, incomplete, misleading or that has been obtained unlawfully.
8. If you have a complaint relating to the processing of your personal information, you agree to refer it to the Administrator to resolve it in terms of their internal complaints process first. If you are not satisfied with the outcome of the complaint, you understand you may refer the complaint to the Information Regulator, who can be contacted on 012 406 4818 or via email at inforeg@justice.gov.za.
9. Your personal information will be shared between Transmed Medical Fund, the Administrator and contracted third parties, both locally and outside the Republic of South Africa, who require this information for purposes related to your membership of Transmed Medical Fund and:
    - to grant you access to interact with Transmed Medical Fund on its website; and
    - to provide any credit bureau or registered credit provider with your credit information, as defined in the National Credit Act, 2005 (credit information includes, for example, your credit history, financial history, pattern of payment or default under any credit agreements, debt re-arrangement arrangements or judgements obtained for outstanding debts).

7. DECLARATION AND AUTHORISATION

I hereby apply to continue as a pensioner member on Transmed and agree that I will be bound by the rules of the Fund, as amended from time to time.

Transmed is hereby authorised to debit my bank account with the monthly contributions paid to Transmed. Transmed is authorised to continue thereafter to deduct each month such contributions and any other amounts that are due until the end of the month in which Transmed is notified of my resignation.

I agree that, should any amount due to the Fund not be timeously paid by me for any reason, I shall be liable for all costs incurred by the Fund in the recovery of such amounts, including tracing charges and all fees due by the Fund to its attorney, including commission.

IMPORTANT: SHOULD THE APPLICATION FORM BE INCOMPLETE, OR IF THE REQUIRED DOCUMENTS ARE NOT ATTACHED, REGISTRATION WILL BE DELAYED, AS THE FORM WILL BE RETURNED FOR CORRECTION.

SIGNATURE OF MEMBER

D	D	M	M	Y	Y	Y	Y

DATE