

#### MEMBERSHIP NUMBER

# MEMBERSHIP AMENDMENT FORM

#### 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. **Working Members:** Once the form has been completed, it should be returned to your Human Resources Department. Your Human Resources Department should forward your completed form to <u>membership@transmed.co.za</u>. **Pensioner Members:** Once the form has been completed, it should be returned to <u>membership@transmed.co.za</u>. You may also fax it to 011 381 2490 or post it to Transmed Membership, PO Box 2269, Bellville 7535. If you require assistance in completing this form, please call 0800 450 010.

#### I. MEMBERSHIP DETAILS (all members must complete this section)

Surname														
First names														
Employee numb	er													
Department/bus (working member	iness ers or	unit nly)												

### 2. TRANSFERS AND SALARY AMENDMENTS

Business unit transferred from																
Business unit transferred to																
Monthly income R							D	ate	D	D	Μ	Μ	Y	Y	Y	Y

#### 3. TEMPORARY SUSPENSION OF MEMBERSHIP

#### Membership to be suspended (e.g. member going overseas for longer than six months)

From	D	D	Μ	Μ	Y	Y	Y	Y	to	D	D	Μ	Μ	Y	Y	Y	Y					
Reason																						

## 4. TERMINATION OF DEPENDANTS' MEMBERSHIP

#### Termination of dependants' membership

Title	1	nitials		s	urna	me								
Relationship														
Reason for terminati	on													
Title	I	nitials		s	urna	me								
Relationship														

### PLEASE NOTE: In the case of divorce, legal documentation is required.

#### 5. MARRIAGE

Member's new surname												

# 6. RESIGNATION OF MEMBERSHIP

nation date	D	D	Μ	Μ	Y	Y	Y	Y	]								
ostal address																	
														Cod	le		

Contact details:

Customer service department 0800 450 010

Email:

membership@transmed.co.za

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# 7. RETIREMENT

Retirement date	D	D	Μ	Μ	Y	Y	Y	Y	(pro	oof of	subsi	idy, m	onthl	y pen	sion	and ir	ncom	e dire	ctly p	rior	to ret	irem	ent re	equire	ed)
Postal address																									
																				Сс	de				
Name of bank																									
Branch name																Bra	nch c	ode [							
Account number																									
Account type		Cur	rent/	Cheo	que		Savi	ngs			Trar	nsmis	sion												

# 8. DEATH OF PRINCIPAL MEMBER

Date of death	D	D	Μ	Μ	Y	Y	Y	Y	(dea pei	ath ce	ertific er be	ate/c nefit	opy o requi	of wid ired)	dow/e	er's ic	lenti	ty do	cume	nt/pr	oof o	of wic	low/e	er's	
Widow/er's postal address																									
																				Co	ode				
Widow/er's ban	k det	ails:																							
Branch name																Brar	nch c	ode							
Account number																									
Account type		Cu	rrent/	Chec	lne		Savi	ngs			Tran	smis	sion												

# 9. CONTACT DETAILS

Email address															
Telephone (W)									(H)						
Fax number							Cell	num	ber						
Postal address															
												Co	ode		

# **10. MEMBERSHIP CARDS**

Number of cards required

For assistance, please contact the customer service department:

Guardian Plan members (SATS pensioners): 0800 110 268 (toll free)

Working Members and Pensioners: 0800 450 010 (toll free)

One calendar month's notice, starting on the first day of the month, is required for any resignation or amendment that affect member contributions.

DD	Μ	Μ	Y	Y	Y	Y
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NAME OF MEMBER

SIGNATURE OF MEMBER

MEMBERSHIP NUMBER										

WORKING MEMBERS: THIS SECTION MUST BE STAMPED AND SIGNED BY AN AUTHORISED HUMAN RESOURCES OFFICIAL AFTER THOROUGH SCRUTINY.

I CERTIFY THE FOREGOING DETAILS TO BE A TRUE STATEMENT.

D D M M Y Y Y Y DATE

SIGNATURE OF HUMAN RESOURCES OFFICER

OFFICIAL EMPLOYER STAMP

IMPORTANT: REGISTRATION WILL BE DELAYED SHOULD THIS APPLICATION BE INCOMPLETE OR IF THE REQUIRED DOCUMENTS ARE NOT ATTACHED.