transmed
MEDICAL FUND

Contact details:
Customer service department 0800 450 010

Email:
membership@transmed.co.za

MEMBERSHIP NUMBER

AFFIDAVIT FOR CONFIRMATION OF INCOME

PLEASE COMPLETE THE FORM IN BLOCK LETTERS.

It is important that all sections of this form be completed in full. 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. If you require assistance in completing this form, please call 0800 450 010.

PERSONAL DETAILS OF PRINCIPAL MEMBER (COMPULSORY TO COMPLETE)

Title | Initials

First name

Surname

Identity/Passport number

Telephone (W) | (H)

Cell number

Email address

Postal address

Code

Residential address

Code

AFFIDAVIT – PROOF OF 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 consequences of submitting inaccurate information could result in the:

- forfeiture of all benefits of the Fund
- refunding in full all amounts for benefits or 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

COMMISSIONER OF OATHS

SIGNATURE OF MEMBER

D D M M Y Y Y Y

DATE