



MEMBERSHIP AMENDMENT FORM

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 membership@transmed.co.za. **Pensioner members:** Once the form has been completed, it should be returned to membership@transmed.co.za. You may post it to Transmed Membership, PO Box 2269, Bellville 7535. If you require assistance in completing this form, please call **0800 450 010**.

PLEASE COMPLETE THE FORM IN BLOCK LETTERS.

MEMBERSHIP NUMBER

1. MEMBERSHIP DETAILS (ALL MEMBERS MUST COMPLETE THIS SECTION)

Title Initials

Surname

First names

Department/Business unit **(Working members only)**

Employee number

2. TRANSFERS AND SALARY AMENDMENTS

Business unit transferred from

Business unit transferred to

Monthly income R Date DD/MM/YYYY

3. TEMPORARY SUSPENSION OF MEMBERSHIP

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

From DD/MM/YYYY to DD/MM/YYYY

Reason

4. TERMINATION OF DEPENDANTS' MEMBERSHIP

Title <input type="text"/>	Initials <input type="text"/>	Surname <input type="text"/>
First names <input type="text"/>		Date of birth <input type="text"/> DD/MM/YYYY
Reason for termination <input type="text"/>		Relationship <input type="text"/> (e.g. spouse)
Title <input type="text"/>	Initials <input type="text"/>	Surname <input type="text"/>
First names <input type="text"/>		Date of birth <input type="text"/> DD/MM/YYYY
Reason for termination <input type="text"/>		Relationship <input type="text"/> (e.g. spouse)

PLEASE NOTE: IN THE CASE OF DIVORCE, LEGAL DOCUMENTATION IS REQUIRED.

5. MARRIAGE

Member's new surname

6. RESIGNATION OF MEMBERSHIP

Resignation date

DD/MM/YYYY

Postal address

Code

7. RETIREMENT

Proof of subsidy, monthly pension and income directly prior to retirement required.

Retirement date

DD/MM/YYYY

Postal address

Code

Account holder

Name of bank

Branch name

Account number

Branch code

Account type

Current/Cheque

Savings

Transmission

8. DEATH OF PRINCIPAL MEMBER

Death certificate/Copy of widow(er)'s identity document/proof of widow(er)'s pensioner benefit required.

Date of death

DD/MM/YYYY

widow(er)'s postal address

Code

Widow(er)'s bank details

Account holder

Name of bank

Branch

Account number

Branch code

Account type

Current/cheque

Savings

Transmission

9. CONTACT DETAILS

Contact numbers

Home:

Work:

Cell phone:

Email address

Postal address

Code

10. MEMBERSHIP CARDS

Number of cards required

For assistance, please contact the customer service department:

Guardian Plan members (SATS pensioners): **0800 111 268** (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 affects member contributions.

Name of member	<input type="text"/>	
Signature of member	<input type="text"/>	Date <input type="text" value="DD/MM/YYYY"/>

WORKING MEMBERS ONLY

This section must be signed and stamped by an authorised Human Resources Official after thorough scrutiny.

I certify the foregoing details to be a true statement.

Signature of Human Resources Officer	<input type="text"/>	Date <input type="text" value="DD/MM/YYYY"/>
Official employer stamp	<input type="text"/>	

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



TRANSMED MEDICAL FUND

Customer service department: **0800 450 010**

Email: membership@transmed.co.za

Website: www.transmed.co.za

05/2026