transmed MEDICAL FUND

FOR ALL OUR PEOPLE

2027 PLAN SELECTION FORM

WORKING MEMBERS AND PENSIONERS

Please complete all the sections in block letters **only** if you wish to change your plan.

YOU HAVE TWO METHODS TO MAKE YOUR PLAN SELECTION

Email the completed form to **membership@transmed.co.za**.

Call the customer service department on **0800 450 010**. Remember to have your membership and identity numbers handy. Please do not submit this form if you have already changed your plan telephonically.

You may only change your plan once a year. This form must reach the Fund by 31 December 2026. If we do not receive your form by this date, your plan change will not be effected.

A. MEMBER DETAILS

Membership number		Current plan	
Title		First name/names	
Surname			
Name of bank		Bank account number	
Branch code		Type	

Please attach a copy of your ID and a bank statement or a stamped letter from your bank (not older than three months).

Postal address					
		City or town		Postal code	
Telephone number (Work)		Telephone number (Home)			
Cell phone number					
Email address					

The information above is required to confirm your plan change and to update our records. Note: All personal information recorded on this form and submitted to Transmed Medical Fund will be processed as set out on this form and as stipulated in Transmed's privacy policy.

B. PLAN SELECTION FOR 2027

You may choose only one plan. Please indicate your choice with an 'X' in the appropriate box.

I hereby confirm that I wish to change to the following plan with effect from 1 January 2027:

☐ Link plan (Universal Healthcare Network)

☐ Select plan

Member's initials and surname	Date	Member's signature
	DD/MM/YYYY	