2024 PLAN SELECTION FORM

WORKING MEMBERS AND PENSIONERS

transmed MEDICAL FUND



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

FOR ALL OUR PEOPLE

YOU HAVE FOUR METHODS TO MAKE YOUR PLAN SELECTION

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

Post the completed form to Transmed Membership Department, PO Box 2269, Bellville 7535

Fax the completed form to **011 381 2041/2** for the attention of the Membership Department.

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 2023. 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: _____

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 (w): ( ) _____ Telephone number (h): ( ) _____

Fax number: _____

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 2024

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 2024:

☐ Link plan (Universal Healthcare Network)
☐ Select plan
☐ Prime plan

Member's initials and surname: _____

Date: _____ Member's signature: _____