

TERMINATION REQUEST

Principal Member Signature: _

Email: creditcontrol@medshield.co.za lease note: Should your termination request reach the Scheme after the 7th business day of the month, your termination will only be																								
effective at the end of the fol				t reac	ii uie	SCIR	enie a	iiter ti	ne /u	ı bus	iiiess	uay c	n uie	ШОП	ui, yo	ur ter	Шпа	lion	WIII OI	ily be				
Principal Member Number:]												
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Principal Member Name/s:																			_					
Principal Member Surname:																								
Termination Effective Date:	D	D	M	M	Υ	Υ	Υ	Υ																
SECTION A	COMPANY APPROVAL (Please note that Medshield cannot process your termination if this section has not been fully completed by your HR Representative/Employer.)																							
Name of Employer:																								
Email Address:																								
Telephone No.:		С	0	D	Е											ļ								
Termination Effective Date:		D	D	М	М	Υ	Υ	Υ	Υ					COMPANY STAMP										
HR Representative's Signatur											_				pleas	e mar	k this	bloc	k with	an X.				
MY REASON FOR TERM	INAT	ION F	RELA	TES	ГО:																			
Mark with an X where necessa	ry.																							
Inadequate Benefits:											Resigned From Employer:													
Increased Contributions:											Retirement:													
Emigrating: Broker Advice:					\vdash							Retrenchment: Condition of Employment:												
Affordability:												Company Liquidation:												
Joining Another Scheme:																								
										_			S	Scheme you are joining										
Hospital Network:												Contact Centre Service:												
FP Network:													Credit Control Service:											
Claims Administration - Bad Service:													Membership Service:											
Underwriting:								Deceased:																
Midyear Option Change:											Loyalty Programme:													
In order for Medshield to imp	rove o	n our	servio	ce del	ivery,	pleas	e give	a bri	ef des	cripti	on of	the is:	sue yo	ou exp	perien	ced:								
Please email the com	pletec	d form	ı to cı	redito	ontro	ol@me	edshie	eld.co	.za al	terna	atively	, fax i	the at	tache	ed for	m ba	ck to	010	597 4	709.				

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Date: