UMVUZO HEALTH

www.umvuzohealth.co.za

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CONTINUATION OF MEMBERSHIP

Membership number		Date	Y	Y	Y	Y	M	M	D	D

DETAILS OF THE PRINCIPAL MEMBER **Race** - **A** = African/Black, **I** = Indian/Asian **W** = White **C** = Coloured

The Hon		Adv		Prof		Dr		Ref		Mr		Mrs		Miss	

Surname															
Full Names															
Member's date of birth	Y	Y	Y	Y	M	M	D	D		Race					
ID number															
Residential address															
										Code					
Postal address															
										Code					
Telephone number (H)															
Telephone number (W)															
Cellphone number															
Email address															
Name of employer									Employee number						
HR Department contact person									Telephone number						

I hereby confirm that I would like to continue my membership with Umvuzo Health Medical Scheme with effect from ____/____/_____ and that I will deposit the relevant monthly contributions directly into the bank account of Umvuzo Health Medical Scheme.

Reason

Member Signature

Date	Y	Y	Y	Y	M	M	D	D