

CONTINUATION OF MEMBERSHIP

Membership number		Date	Y	Y	Y	Y	M	M	D	D
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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									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
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