OPTION CHANGE FORM

This form to be sent to: COMMUNITY MEDICAL AID SCHEME

- Private Bag X146, Halfway House, 1685
- Fax: 011 783 5084
- membership@allcare.co.za

It is imperative that you complete and return this form to us by fax on (011) 783 5084 by 31 December 2016. A copy of this form must be submitted to your payroll department for information. Please note that late requests for option changes will not be considered.

NB. Kindly consider the enclosed benefit table and rate table, select your option and advise your employer as soon as possible.

Section 1	OPTION CHANGE FORM 2017		
Name and Surname		Membership No.	
Employer Name		Identity No.	
Telephone No.		Cell No.	
E-mail		Gross Monthly Income	
Address			

Section 2	CURRENT OPTION (2016)	NEW OPTION (2017)
DELUXE		
STANDARD		
SHINA		
ROOTS (If choosing this option, please complete the Doctors Choice Form)		

Section 3 DECLARATION

I confirm that I made the choice of option after considering my personal requirements and those of my dependants and have not been influenced in any way by either Community Medical Aid Scheme or any employee of Allcare Administrators (Pty) Ltd.

I confirm that to prevent the risk of concluding a transaction that is not appropriate to my needs, objectives and circumstances; I should obtain a full healthcare needs analysis from a Healthcare Advisor.

I, the undersigned, hereby give my informed consent that any hospital, medical or dental practitioner who has treated me or any of my beneficiaries, may disclose any records and test results relating to such treatment to, or undertake to assist in obtaining any information from its records that the Scheme may require to conduct pre-authorisation of future treatment, to perform managed healthcare functions and to undertake forensic investigations.

I undertake to obtain the necessary consents from any of my dependants to whom these conditions may apply and hereby indemnify the Scheme and/or administrator against any claim which may arise as a result of my failure to do so.

I, the undersigned, hereby authorise the Scheme, or its representatives, to assist all my beneficiaries, my medical practitioners and/or me in managing our medical expenses.

Signature		Date	
Employer sign-off		Date	