bonitas medical fund

Serious about what you need

APPLICATION FOR CHANGE OF OPTION

P.O. Box 1101, Florida Glen 1708
Call Centre 0860 002 108
Fax 011 758 7917
E-mail bonitasschemefinance@medscheme.co.za

Please Note

- If you select the BonCap option, you as the principal member and each of your dependants, may only consult with the Prime Cure GP network.
- If you select Standard and or the Primary options use the Bonitas GP Network that is available in your area. If a Network GP is not available in the area then you can use any GP in the area.
- the option change form must be completed and returned to us by the 10th December 2009.
- If you are an employee of a private company, submit your form to your Human Resources / Salaries Department.
- No form will be processed without your employer's stamp.
- If you are a direct paying member, send your form to Bonitas Medical Fund at the above address, fax number or email address.

Remember to submit the option change form before the closing date for 2010 benefits.

FOR ADMINISTRATIVE USE

Membership number

Pay-point code

Section 1 TO BE COMPLETED BY THE PRINCIPAL MEMBER

Title

Initials

Membership number

First name/s

ID number

Surname

Home address

Postal address

E-mail address

Telephone (H) c o d e

Cell

Telephone (W) c o d e

Fax c o d e

Wish to change my option to: *(Please select an option below by inserting an 'X' in the appropriate block)*

☐ **BONCOMPREHENSIVE** ☐ **BonEssential** ☐ **BONSAVE** ☐ **STANDARD** ☐ **PRIMARY**

☐ **BONCAP –** *If you select BonCap, please note that you may only obtain treatment from a Prime Cure network doctor and hospital. If you select this option you must attach a copy of your salary advice. Please contact the Prime Cure call centre on 0861 665 665 or visit www.primecure.co.za for a list of contracted service providers in your area.*

☐ **R0 – R4 400** ☐ **R4 401 – R7 200** ☐ **R7 201+**

Income bands (BonCap only) tick the applicable band

Member Declaration
I understand that this written notice to change my option will apply from 1 January 2010 for the year. I further understand that I will be responsible for the full payment of the contributions on a monthly basis.

Member's signature ______________________

Date d d m m y y y y

Section 2 TO BE COMPLETED BY EMPLOYER / PENSION FUND

Name of employer

The above details have been noted and approved.

Number of adult dependants

Number of child dependants

Signature ______________________

Designation (e.g. manager etc.) ______________________

Date d d m m y y y y

COMPANY STAMP