Transfer from Active to Retiree Status

SAB The South African Breweries | Medical Aid

Contact details
Tel: 0860 002 133 • PO Box 652509, Benmore 2010 • www.sabmas.co.za

This form is for principal members who move onto retiree status, to make contributions or payments directly to SAB Medical Aid.

Who we are

SAB Medical Aid (referred to as 'the Scheme'), registration number 1209, is a non-profit organisation, registered with the Council for Medical Schemes. 3Sixty Health (Pty) Ltd, registration number 1978/001109/07, (referred to as 'the administrator') is a separate company and an authorised financial services provider and is responsible for the administration of your membership on behalf of the Scheme.

How to complete this form

1. Please use one letter per block, complete with black ink and print clearly.
2. Please complete this form and return it to your Human Resources department.
3. To avoid administration delays, please make sure this application is completed in full.
4. Please contact the SAB Medical Aid Customer Care Centre on 0860 002 133 for any queries.

1. Member information (main applicant)

Membership number (compulsory) Start date Y Y Y Y M M D D

Employee number (compulsory)

Title Initials Surname

First name/s

Preferred name Gender M F Date of birth Y Y Y Y M M D D

Marital status: Married ☐ Single ☐ Divorced ☐ Widowed ☐ Date of marriage Y Y Y Y M M D D

Previous/maiden name

ID or passport number

Country of issue

Telephone (H) (W)

Fax Cellphone

Email address

Postal address

Code

Residential address

Code

2. Banking details for your monthly contributions

You need to submit the following with this form:
– Copy of the account holder's ID
– Bank statement or letter of confirmation from the bank not older than three months. Please note: only an original bank statement will be accepted.

These details apply when you pay directly towards your total contribution. Please note that we cannot accept credit card details. You can only use a South African bank account. The first deduction will take place at the beginning of the month following the start date as a retiree member.

Bank name Branch name

Account type: Current ☐ Transmission ☐ Savings ☐ Branch code – –

Name of account holder

Account number

Signature of account holder

I _____, hereby give 3Sixty Health and/or SAB Medical Aid permission to charge my bank account for my contributions to SAB Medical Aid.

3. Banking details for reimbursement of your claims

You need to submit the following with this form:
– Copy of the account holder's ID
– Bank statement or letter of confirmation from the bank not older than three months. Please note: only an original bank statement will be accepted.

Same as above? Yes ☐ No ☐ (if "No", please complete below)

Bank name Branch name

Account type Current ☐ Transmission ☐ Savings ☐ Branch code – –

Name of account holder

Account number

Signature of account holder

4. Your legal declaration

It is my sole responsibility as a member, to make sure SAB Medical Aid receives the monthly contributions. If contributions are outstanding for two months in a row, my membership will be cancelled in the third month. Short payment or non-payment of any of my contributions will result in suspension of my claims.

I confirm the content of this application is true and complete.

I agree to advise SAB Medical Aid in writing of any change in details, that may occur between the date of this application and the activation of my membership with SAB Medical Aid.

Signed at on Y Y Y Y M M D D

Signature of applicant

Please do not sign an incomplete application form

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