BENEFIT OPTION SELECTION

A Member of AfroCentric Group
medscheme
ESWATINI

SECTION 1: To be completed by member

Title | Initials

First names

Surname

Membership number

I, _____ wish to change the Benefit Options as indicated below:

OPTION

- ◯ Comprehensive Plan
- ◯ Flexible Plan
  - ◯ Level 0
  - ◯ Level 1
  - ◯ Level 2
  - ◯ Level 3
  - ◯ Level 4
  - ◯ Level 5
- ◯ Primary Care Plan
- ◯ Tertiary Care Plan
- ◯ Hospital Cash Plan
- ◯ Achiever Plan

Effective date of the change D D M M Y Y Y Y

Member's signature

Date D D M M Y Y Y Y

Consent to disclose medical information

In the event that I or any of my dependants require hospitalization, I hereby consent that any medical practitioner or specialist may disclose all medical information relating to me and any of my dependants in their possession to Medscheme Eswatini whenever requested for the Fund to manage hospitalization costs against available benefits.

I indemnify the medical practitioner(s) or specialist who have disclosed information in terms of this consent, against any claims that may arise as a result of their disclosure of information.

Member's signature

Date D D M M Y Y Y Y

SECTION 2: To be completed by employer

Employer name

The above changes have been noted and will be applied accordingly.
Contributions will be adjusted in line with the selected option(s) with effect from date: D D M M Y Y Y Y

Signature

Designation

Date D D M M Y Y Y Y

Company stamp

SECTION 3: Internal use only

Approved by | Date D D M M Y Y Y Y

Processed by | Date D D M M Y Y Y Y

New option number