CELLMED HEALTH
MEDICAL FUND

CELLMED MEMBERSHIP AMENDMENT FORM

ALL PERSONAL INFORMATION COLLECTED SHALL BE USED IN THE PROVISION OF MEDICAL AID AND RELATED SERVICES

SECTION I: EMPLOYER/INDIVIDUAL ACCOUNT HOLDER'S DETAILS

Name of employer / Account holder:

Authorised signatory:

Principal member full name:

Membership number:

Commencement Date: dd/mm/yyyy

SECTION II: MEMBER AMENDMENT

NOTE: LEAVE BLANK WHERE NO AMENDMENTS ARE REQUIRED

I wish to ☐ Add ☐ Terminate ☐ Amend member(s) as follows:

Beneficiaries

Full name	Date of Birth	Relationship	ID Number	Add	Terminate	Amend
	dd/mm/yyyy			◯	◯	◯
	dd/mm/yyyy			◯	◯	◯
	dd/mm/yyyy			◯	◯	◯
	dd/mm/yyyy			◯	◯	◯
	dd/mm/yyyy			◯	◯	◯
	dd/mm/yyyy			◯	◯	◯
	dd/mm/yyyy			◯	◯	◯

Medical History (To be completed only when adding member)

Full Name	Pre-existing conditions	Treatment Administered	Name of Doctor	Doctor's Telephone

SECTION III: PLAN DETAILS

NOTE: LEAVE BLANK WHERE NO AMENDMENTS ARE REQUIRED

I wish to ◯ Amend **OR** ◯ Maintain my membership as follows:

Plan

Current Plan	
New	

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SECTION IV: CONTACT DETAILS

NOTE: LEAVE BLANK WHERE NO AMENDMENTS ARE REQUIRED

I wish to amend my contact details as follows:

Residential address:

Business Tel: Home Tel:

Mobile: Email address:

SECTION V: BANKING DETAILS

NOTE: LEAVE BLANK WHERE NO AMENDMENTS ARE REQUIRED

BANKING DETAILS TO BE ADDED MUST BE IN THE SAME CURRENCY YOUR COVER IS IN

I wish to amend my banking details as follows:

Bank Account Holder Name:

Name of Bank:

Account Number (ZWG):

Account Number (USD):

Branch:

Branch Code:

SECTION VI: REASONS FOR AMENDMENT

DECLARATION

I ..... certify that the information given above was submitted willfully and is correct. I agree that should my application be accepted, I will abide by the rules, benefits and regulations set by CellMed Health Medical Fund (CellMed); details of which are available on request. The signing of this contract signifies the basis of the contract between CellMed and myself.

I hereby consent and authorize CellMed Health Medical Fund to collect biometrics for all beneficiaries specified in this membership application. This collection is essential for verification, claims submission and validation processes.

Member Signature: SIGN HERE Date: dd/mm/yyyy

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