LIBERTY MEDICAL SCHEME

We care. **For you**

Private Bag X35
Claremont, 7735
Contact Centre 0860 002 163
Membership fax 021 673 9587
www.libmed.co.za

Employer Group Resignation Form

SECTION 1 – DETAILS OF EMPLOYER GROUP

Note: If the entire group is resigning, three calendar months notice is required. The effective date will be on the last day of the third month after notification is received.

Employer name ____________________

Group code | L | B | T | | | | | | | | |

Group contact person ____________________ Telephone number ____________________

Total number of members resigning ____________________ (including pensioners)

Date of resignation | Y | Y | Y | Y | M | M | D | D |

Reason for leaving ____________________

____

Do you require someone to contact you with regards to this resignation? | Y | | N |

Full name of authorised signatory ____________________

Capacity/Designation ____________________

Date | Y | Y | Y | Y | M | M | D | D |

DECLARATION:

I declare that the above information is true and correct.

1. I hereby confirm that the members are aware of the following:
   1.1 That they are responsible for any negative balance in their Medical Savings Facility (where applicable).
   1.2 That Liberty Medical Scheme will hold any Medical Savings Facility balance for four months after the effective date of resignation, in order to process any outstanding Medical Savings Facility claims. After the fourth month, the Medical Savings Facility balance will be paid out in one of the following ways:
      a. If the members transfer to another registered medical scheme that offers a Medical Savings Facility option, the positive Medical Savings Facility balance will be transferred to the new medical scheme. Please note that as soon as we have confirmation of the new membership numbers with the new medical scheme, these shall be forwarded to Liberty Medical Scheme to aid in the transfer of positive balances, together with the banking details of the new medical scheme.
      b. Refunded to the member's bank account details that the Scheme has on record if member has no Medical Savings Facility at the new medical scheme.
2. Any outstanding negative Medical Savings Facility balance is payable by the members on resignation.
3. The resignation includes all our Pensioners who were eployed with the Group, and have transferred to Direct Paying Members (DPM).

Signed at ____________________ on this __________ day of __________ 20 ____

____

Signature of Authorised Signatory

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SECTION 2 – DETAILS OF PRINCIPAL MEMBER

(Please ensure that each member completes this section). * Denotes compulsory information

Membership number*

Member name(s)*

Member surname*

Resignation effective date Y Y Y Y M M D D

Bank name

Branch name

Branch code

Account number

Account type CHEQUE TRANSMISSION SAVINGS

Name of account holder

Physical address*

Postal code

Postal address*

Postal code

Telephone number Fax number

Cellphone number

Email address

Note: Please attach a copy of the ID document of the account holder and a copy of a cancelled cheque or a posted bank statement.

NEW MEDICAL SCHEME DETAILS (for transfer of positive Medical Savings Facility balances)

Will you be joining another medical scheme after resigning your membership with Liberty Medical Scheme? Y N

If yes, does this Medical Scheme have a Medical Savings Facility option? Y N

Registered Medical Scheme membership number

Registered Medical Scheme address

Postal Code

Registered Medical Scheme contact person

Telephone number Fax number

Email address

DECLARATION

I declare that the information above is true and correct. I also confirm that I am aware of the resignation of my membership of the Liberty Medical Scheme with effect Y Y Y Y M M D D to transferance to

Note:
Liberty Medical Scheme will not bear any responsibility for delays due to incorrect details or proof of account holder not being supplied.

Signature of Principal member

Date

SECTION 3 – DETAILS OF FINANCIAL ADVISER

I, ______________________________ (Financial adviser name/surname) 13 digit broker code [| | | | | | | | | | | |] confirm that I have knowledge that the above member is resigning their membership with Liberty Medical Scheme with effect from Y Y Y Y M M D D

Reason for resignation ______________________________

Signature of Financial Adviser ______________________________ Date Y Y Y Y M M D D

Telephone number (Work) [| | | | | | | | |] Fax number [| | | | | | | | |]

Cellphone number [| | | | | | | | |]

Email address [ ]

Please return the form(s) by fax to 021 673 9587 or alternatively email a scanned version to updates@libertyhealth.co.za.

For any queries please contact the Liberty Medical Scheme Contact Centre on 0860 002 163.

Please note that in event of any modifications of variation of this standard form, Liberty Medical Scheme will regard this form as being invalid and of no force and effect.