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

Membership Record Amendment Form

General

Membership number*

Member name(s)*

Member surname*

***Denotes compulsory information**

Record Amendment Type

(indicate with an "X" in the appropriate box)

- [ ] Change of contact details
- [ ] Resignation of dependant
- [ ] Change in marital status
- [ ] Change in bank details

Effective date of change(s) Y Y Y Y M M D D

Change of Contact Details

Old Address		New Address	
Post code		Post code	
Cell		Cell	
Telephone (home)		Telephone (home)	
Telephone (work)		Telephone (work)	
Fax		Fax	
Email		Email	

Change in Marital Status

(indicate with an "X" in the appropriate box)

- [ ] Married
- [ ] Divorced
- [ ] Widowed

Date of Marriage/Divorce/Death Y Y Y Y M M D D

Title

Initials

New surname (if applicable)

Note:

MARRIED Attach a certified copy of Marriage Certificate. If spouse is to be added, complete a Dependant Registration form.

DIVORCED Attach a certified copy of Divorce Order. If spouse is to be resigned, complete the resignation of dependant section on this form.

WIDOWED Attach a certified copy of Death Certificate of spouse.

For registration of any new dependant, please complete a Dependant Registration form.

LIBERTY

Resignation of Dependant

Title	Full name/s and surname	ID number	Resignation date	Reason for resignation
			Y Y Y Y M M D D	
			Y Y Y Y M M D D	
			Y Y Y Y M M D D	
			Y Y Y Y M M D D	

Note:

DEATH Attach a certified copy of Death Certificate – complete "Change of Marital Status" section on this form if death of spouse.

DIVORCE Attach a certified copy of Divorce Order – complete "Change of Marital Status" section on this form if divorced from spouse.

Change in Bank Details

Debit order details

Branch code

Account No.

Type of account (tick appropriate box)

CURRENT TRANSMISSION SAVINGS

Effective date of charge Y Y Y Y M M D D

Claims refund details

Branch code

Account No.

Type of account (tick appropriate box)

CURRENT TRANSMISSION SAVINGS

Effective date of charge Y Y Y Y M M D D

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

Full name of Account holder

Account Holder's Signature

Principal Member's Signature
(if different from Account holder)

DECLARATION:

I declare that the above information is true and correct and that the above details have been noted and where applicable the contributions will be adjusted in terms of the Scheme rules.

I hereby authorise the Scheme to disclose my personal banking details to CareCross in order to allow the scheme to fulfil its functions, duties and obligations.

In an effort to keep you updated on activities at Liberty Medical Scheme (LMS), we have been sending you various types of marketing and health related product communications in the form of emails, sms's and post. We would like to ensure receiving these communications are more convenient for you and we request that you complete the section below and return it to the Scheme.

Do you wish to continue receiving LMS marketing communications? Y N

If yes, how would you like to receive them? Email Y N SMS Y N Post Y N

I consent to LMS marketing products, services and special offers being sent to me from time to time. Y N

I consent to LMS sharing my membership information with any Third Party Provider contracted to LMS for the delivery of healthcare services to allow the Scheme to fulfil its functions. Y N

I consent that such contracted Third Party may contact me from time to time regarding their products, services and special offers. Y N

Signature of Principal member

Signed at on this day of 20

Please return the form 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.

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