

Contact details

Tel: 0800 001 615 • PO Box 652509, Benmore, 2010 • www.engenmed.co.za

Transfer from active to retiree status

Who we are

Engen Medical Benefit Fund (referred to as 'EMBF'), registration number 1572, is a not-for-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, (referred to as 'the administrator') is a separate company, an authorised financial services provider and is responsible for the administration of your membership on behalf of the Fund.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. This form is for main members who are retiring from active employment with the Employer who will be making direct contribution payments to Engen Medical Benefit Fund.
3. To avoid administration delays, please ensure this application is completed in full.
4. Once completed, please return this form to your Human Resources department.
5. Please call Engen Medical Benefit Fund on 0800 001 615 for any queries.

1. Member information (main applicant)

Membership number (compulsory)	<input type="text"/>	Start date	<input type="text"/>
Employee number (compulsory)	<input type="text"/>		
Title	<input type="text"/>	Initials	<input type="text"/>
Surname		<input type="text"/>	
First name/s	<input type="text"/>		
Preferred name	<input type="text"/>	Sex	<input type="text"/>
		Date of birth	<input type="text"/>
Marital status:	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Date of marriage	<input type="text"/>
Previous/maiden name	<input type="text"/>		
ID or passport number	<input type="text"/>		
Country of issue	<input type="text"/>		
Telephone (H)	<input type="text"/>	(W)	<input type="text"/>
Fax	<input type="text"/>	Cellphone	<input type="text"/>
Email address	<input type="text"/>		
Postal address	<input type="text"/>		
			Code <input type="text"/>
Residential address	<input type="text"/>		
			Code <input type="text"/>

2. Banking details for your monthly contributions

What you must do

Submit the following with this form: A copy of your ID and a bank statement/letter of confirmation from the bank.

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 Discovery Health (Pty) Ltd and/or Engen Medical Benefit Fund permission to charge my bank account for my contributions to Engen Medical Benefit Fund.

3. Banking details for reimbursement of your claims

What you must do

Submit the following with this form: A copy of your ID and a bank statement/letter of confirmation from the bank.

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 Engen Medical Benefit Fund receives the monthly premium. 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 Engen Medical Benefit Fund in writing of any change in details that may occur between the date of this application form and the activation of my membership with Engen Medical Benefit Fund.

Signed at on

Signature of applicant

Please do not sign an incomplete application form

5. Your employment details

If your employer is paying your full contribution or a part of it, please complete this section:

Name of employer
Employer / billing number
Employee number Date of employment

1. Employer contact person <input type="text"/> Telephone <input type="text"/> Email <input type="text"/> Branch name <input type="text"/> Department name <input type="text"/> Date of promotion (if applicable) <input type="text"/>	2. Employer contact person <input type="text"/> Telephone <input type="text"/> Email <input type="text"/> Branch number <input type="text"/> Department number <input type="text"/>
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Please ensure your employer completes this warranty.