

Transfer from active to retiree status 2026

Who we are

Engen Medical Benefit Fund (referred to as "the Fund"), 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. Alternatively, complete it digitally.
2. This form is for main members who are retiring from the employer's active employment, 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. Details of Principal Member

Membership number (compulsory)	<input type="text"/>	Retirement 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"/>		
Previous/maiden name	<input type="text"/>		
ID or passport number	<input type="text"/>	Tax payer number	<input type="text"/>
Gender	M <input type="checkbox"/> F <input type="checkbox"/>	Date of birth	<input type="text"/>
Marital status	Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>	Date of marriage	<input type="text"/>
Telephone (H)	<input type="text"/>	Telephone (W)	<input type="text"/>
Cellphone	<input type="text"/>		
Email	<input type="text"/>		
Postal address (Post collected from post box, suite or private bag)			
<input type="checkbox"/> PO Box	<input type="checkbox"/> Private bag	Box number	<input type="text"/>
<input type="checkbox"/> Suite	<input type="checkbox"/> PostNet suite	Number	<input type="text"/>
Suburb	<input type="text"/>		
City	<input type="text"/>		Postal code <input type="text"/>
Physical address			
Unit/Suite number	<input type="text"/>	Complex/Building	<input type="text"/>
Street number	<input type="text"/>	Street name	<input type="text"/>
Suburb	<input type="text"/>		
City	<input type="text"/>		Postal 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 (not older than three months) from the bank.

These details apply when you pay directly towards your total contribution. Please note that we cannot accept credit card details. You may 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			Branch code	<input type="text"/>	- <input type="text"/>	- <input type="text"/>		
Account number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Account type	Current <input type="checkbox"/>	Transmission <input type="checkbox"/>	Savings <input type="checkbox"/>
Account holder name								
Signature of account holder								

I, _____, hereby give the Administrator and/or the 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 (not older than three months) from the bank

Same as above? Yes No (if "No" please complete below)

Bank name								
Branch name			Branch code	<input type="text"/>	- <input type="text"/>	- <input type="text"/>		
Account number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Account type	Current <input type="checkbox"/>	Transmission <input type="checkbox"/>	Savings <input type="checkbox"/>
Account holder name								
Signature of account holder								

4. Your legal declaration

It is my sole responsibility as a member to ensure Engen Medical Benefit Fund receives my monthly contributions. Should contributions be outstanding for two months in a row, my membership will be suspended, and if it remains unpaid, cancelled in the third month. Short payment or non-payment of any of my contributions will result in suspension of claims payments.

I confirm the content of this application is true and complete.

Signed at (town or city)		on	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Signature of main member									

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	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>					
Employee number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>					
Date of employment	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>					
1. Employer contact person	Telephone					2. Employer contact person					Telephone				
Email					Email					Email					
Branch name					Branch name					Branch name					
Department name					Department number					Department number					

Please ensure your employer completes this warranty.