UMVUZO HEALTH

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REINSTATE DEPENDANT OVER 21

Membership number		Date	Y	Y	Y	Y	M	M	D	D

DETAILS OF THE PRINCIPAL MEMBER

Race - **A** = African/Black, **I** = Indian/Asian **W** = White **C** = Coloured

Dr		Ref		Mr		Mrs		Miss	

Surname	
Full Names	
Member's date of birth	Y Y Y Y M M D D Race
ID number	
Residential address	
	Code
Postal address	
	Code
Telephone number (H)	
Telephone number (W)	
Cellphone number	
Email address	
Name of employer	Employee number
HR Department contact person	Telephone number

DEPENDANT OVER 21

Race - **A** = African/Black, **I** = Indian/Asian **W** = White **C** = Coloured

Full Names		Surname	
Date of birth	Y Y Y Y M M D D	Gender	Race
ID number			

I _____hereby declaire that I want the above dependant to stay active on my medical aid as an dependant. I also understand that the contribution will change from child to adult dependant premium.

Member Signature — Date Y Y Y Y M M D D

Namestamp of employer

Human Resource Manager / Practitioner Signature — Date Y Y Y Y M M D D