UMVUZO HEALTH

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REINSTATE DEPENDANT OVER 25

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 25

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