Reg. No.: 1464
7 Lutman Street, Richmond Hill, Port Elizabeth, 6001
P.O. Box 1672, Port Elizabeth, 6000
Customer Care\Hospital Authorisations: 0860080888
Email: info@suremedhealth.co.za
www.suremedhealth.co.za

OPTION SELECTION FORM

NB: ONLY COMPLETE THIS FORM IF YOU WANT TO **CHANGE** FROM YOUR CURRENT OPTION. PLEASE IMMEDIATELY SUBMIT TO YOUR EMPLOYER OR TO SUREMED HEALTH TO ENSURE THAT THE FORM REACHES US BY 30th NOVEMBER 2021.
Fax : 0867430677 or email membership@suremedhealth.co.za

SECTION A – TO BE COMPLETED BY MEMBER

I, …… (name of member)

Membership No. | | | | | | | | | | | | |

Current Option: _____

wish to change to the following option (please tick appropriate box):

SUREMED OPTION FOR 2022

Challenger		Navigator		Shuttle		Explorer	

DECLARATION

1. I hereby acknowledge that I am familiar with the conditions and benefits of the option selected, notwithstanding representation by another party.
2. I understand that I must give written notice by 30 November 2021 of my intent to transfer to a new benefit option, which becomes effective 1 January 2022. I also accept that I can only change options once a year, will remain on this option until 31 December 2021 and will be responsible for the full payment of monthly contributions due.

Member's Signature …… Date …… Contact Number……

PLEASE NOTE:

1. You are allowed to move from one option to another, once a year – i.e. on 1 January, each year.
2. If you choose a benefit option other than your existing option, you will be issued with a revised membership card. Therefore, prompt response in returning the option selection will be greatly appreciated.
3. If you are joining the Explorer option, please note that you may only use a Prime Cure network provider and network hospital. Contact the Suremed Health call centre on 0860 0808 88 or visit www.suremedhealth.co.za for an updated list of contracted providers. Please ensure that you complete a GP nomination form.
4. For the Explorer and Shuttle options, please complete the income verification form and provide proof of income in the form of:

- Latest salary slip
- 3 months bank statements
- Latest Tax Assessment IT34

SECTION B – TO BE COMPLETED BY EMPLOYER (where employer pays contributions on your behalf)

Name of Employer: ……..

Signature: ……

Designation: ……

OFFICIAL EMPLOYER STAMP

Date: | Y | Y | Y | Y | M | M | D | D |