



## 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 2024.  
 Email to: [membership@suremedhealth.co.za](mailto:membership@suremedhealth.co.za)

### SECTION A – TO BE COMPLETED BY MEMBER

I, ..... (name of member)

Membership No.

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Current Option: \_\_\_\_\_

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

### SUREMED OPTION FOR 2025

Challenger		Navigator		Shuttle		Explorer	
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#### DECLARATION

- I hereby acknowledge that I am familiar with the conditions and benefits of the option selected, notwithstanding representation by another party.
- I understand that I must give written notice by 30 November 2024 of my intent to transfer to a new benefit option, which becomes effective 1 January 2025. I also accept that I can only change options once a year, will remain on this option until 31 December 2025 and will be responsible for the full payment of monthly contributions due.

Member's Signature ..... Date ..... Contact Number.....

#### PLEASE NOTE:

- You are allowed to move from one option to another, once a year – i.e. on 1 January, each year.
- 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.
- If you are joining the Explorer option, please note that you may only use a Primary Care network provider and network hospital. Contact the Suremed Health call centre on 0860 0808 88 or visit [www.suremedhealth.co.za](http://www.suremedhealth.co.za) for an updated list of contracted providers.
- 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: .....

Date:

Y	Y	Y	Y	M	M	D	D
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OFFICIAL EMPLOYER STAMP