genesis
MEDICAL SCHEME

OPTION CHANGE REQUEST FORM

Membership Number:

First Name:

Surname:

Email Address:

Cell Number:

Alternative Number:

Current Benefit Option: *(please tick relevant option)*

MED-100		MED-200		MED-200 PLUS	

Change to Benefit Option: *(please tick relevant option)*

MED-100		MED-200		MED-200 PLUS	

To take effect from: D D M M 2 0 Y Y

Do you, your spouse or any of your dependants expect to seek medical advice or treatment in the next 6 months?

Reason for the request to change Benefit Option:

Member Signature:

Date:

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