



TERMINATION REQUEST

Email: creditcontrol@medshield.co.za

Please note: Should your termination request reach the Scheme after the 7th business day of the month, your termination will only be effective at the end of the following month.

Principal Member Number:

Principal Member Name/s:

Principal Member Surname:

Termination Effective Date:

SECTION A **COMPANY APPROVAL** (Please note that Medshield cannot process your termination if this section has not been fully completed by your HR Representative/Employer.)

Name of Employer:

Email Address:

Telephone No.:

Termination Effective Date:

COMPANY STAMP

Tick this box if no Company Stamp is available

By selecting this box you confirm that the Employer has granted approval

HR Representative's Signature: _____

MY REASON FOR TERMINATION RELATES TO:

Mark with an X where necessary.

Inadequate Benefits:	<input type="checkbox"/>	Resigned From Employer:	<input type="checkbox"/>
Increased Contributions:	<input type="checkbox"/>	Retirement:	<input type="checkbox"/>
Emigrating:	<input type="checkbox"/>	Retrenchment:	<input type="checkbox"/>
Broker Advice:	<input type="checkbox"/>	Condition of Employment:	<input type="checkbox"/>
Affordability:	<input type="checkbox"/>	Company Liquidation:	<input type="checkbox"/>
Joining Another Scheme:	<input type="checkbox"/>		

		<i>Scheme you are joining</i>	
Hospital Network:	<input type="checkbox"/>	Contact Centre Service:	<input type="checkbox"/>
FP Network:	<input type="checkbox"/>	Credit Control Service:	<input type="checkbox"/>
Claims Administration - Bad Service:	<input type="checkbox"/>	Membership Service:	<input type="checkbox"/>
Underwriting:	<input type="checkbox"/>	Deceased:	<input type="checkbox"/>
Midyear Option Change:	<input type="checkbox"/>	Loyalty Programme:	<input type="checkbox"/>

In order for Medshield to improve on our service delivery, please give a brief description of the issue you experienced:

Please email the completed form to creditcontrol@medshield.co.za alternatively, fax the attached form back to 010 597 4709.

Principal Member Signature: _____

Date: