

<b>NATIONAL TREASURY</b> <b>Government Employees</b> <b>Pension Fund (GEPF)</b>  <b>MEDICAL SCHEME</b> <b>MEMBERSHIP – Z583</b>		<b>GEPF USE ONLY - GEPF STAMPS</b>	<b>BAR CODE</b>

### PARTICULARS OF MEDICAL SCHEME MEMBERSHIP

This form enables the GEPF to successfully process the application for continued Medical assistance or to indicate a change in Medical Scheme Particulars.

**COMPULSORY ATTACHMENTS:** See section B.

#### A) TYPE OF APPLICATION - Please select only one option

1. Application for continued Medical Assistance after Retirement/Death in Service (Resolution 3 of 1999 and Resolution 1 of 2006) (Compulsory items: B,D,E,F,G,H,I,J and K. C in case of death)
2. Continued Membership of Medical Scheme - Change of Medical Scheme Particulars (Compulsory items: B,D,E,F,G,H and K)
3. Application of Widow / Widower for continued Membership of Medical Scheme (Compulsory items: B,C,D,E,F,G and K)

#### B) COMPULSORY ATTACHMENTS

*All copies of ID documents should be clear, and should not be older than 6 months.*

*Only applicable to Type 2 Applications:*

- |                                                                                                                  |                          |                                   |                          |
|------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------------------------|--------------------------|
| 1. Certified copy of ID of the main member of the Medical scheme.                                                | <input type="checkbox"/> | Copy of last Salary Advice        | <input type="checkbox"/> |
| 2. Proof of all the dependants registered on your medical scheme. Certified copy of ID and or birth certificate. | <input type="checkbox"/> | Completed Z894 - Bank particulars | <input type="checkbox"/> |
| 3. Membership Certificate from your medical scheme.                                                              | <input type="checkbox"/> | Service Certificate               | <input type="checkbox"/> |
| 4. Member Death Certificate (if applicable)                                                                      | <input type="checkbox"/> |                                   |                          |
| 5. Please include previous medical scheme certificate(s).                                                        | <input type="checkbox"/> |                                   |                          |

#### C) PERSONAL PARTICULARS OF DECEASED MEMBER

Pension Number

Surname

First Name

Middle Name

Maiden Name

Title  Init  D.O.B  ID No

Date of Death  Marital Status  Married  Unmarried  Widow/er  Divorced  Life Partner

#### D) PERSONAL PARTICULARS OF APPLICANT

Pension Number

Surname

First Name

Middle Name

Maiden Name

Title  Init  D.O.B  ID No

Income Tax No  Marital Status  Married  Unmarried  Widow/er  Divorced  Life Partner

#### E) CONTACT PARTICULARS OF APPLICANT

Postal Address <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Postal Code <input type="text"/>	Residential Address <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Postal Code <input type="text"/>
Tel No <input type="text"/> <input type="text"/>	Cell No <input type="text"/> <input type="text"/>
E-Mail <input type="text"/>	

**ALL PAGES OF THIS FORM MUST BE COMPLETED IN ORDER FOR THIS FORM TO BE VALID AND THE MEMBER OR PENSIONER AND COMMISSIONER OF OATHS MUST INITIAL THIS PAGE.**

Member/Pensioner initial  Commissioner of Oaths initial

Pension Number

**F) PARTICULARS OF DEPENDANTS - For any dependant registered on your medical scheme**

	Surname	First Name	ID No / Passport number	Type *
1.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
6.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
7.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
8.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

\* 1-Spouse 2-Child 3-Disable 4-Student 5-Life Partner 7-Mother 8-Father 9-Grandchild A-Sister B-Brother

**G) PARTICULARS OF MEDICAL SCHEME**

*The Medical Scheme details refer to the current and new medical scheme*

Medical Scheme Name

Medical Scheme Number

Would you like to continue your membership?  Yes  No

Date of Benefit

Membership Commencement Date

**H) PARTICULARS OF PREVIOUS MEDICAL SCHEME**

Date on which membership was terminated

Medical Scheme Name

Medical Scheme Number

**I) CHOICE FOR MEDICAL BENEFIT UPON RETIREMENT / DEATH**

*A single choice between Option A or Option B is compulsory - Please indicate clearly*

**1. OPTION A - Continued State Subsidised Membership**

Subject to 12 months continued membership of a registered medical fund on the last day of service and previous government service exceeding:

- 15 Years in respect of retirement
- 10 years in respect of medical discharge

Employer Name

Start Date

End Date

Employer Name

Start Date

End Date

Employer Name

Start Date

End Date

Employer Name

Start Date

End Date

**OR**

**2. OPTION B - Gratuity Payment (Once-off cash amount)**

Subject to 12 months continued membership of a registered medical fund on the last day of service only if less than:

- 15 Years in respect of retirement
- 10 years in respect of medical discharge

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**J) TO BE COMPLETED BY THE LAST EMPLOYER DEPARTMENT**

State Contribution to member medical aid on last day of service

Last day of employment

Reason for retirement

Service record in government departments or related institutions. All periods of service must be furnished:

From	To	Department or Institution
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

I certify that all particulars in this form are true and correct.

Official Date Stamp of Employer

Signature 1

Designation

Surname of Employer Representative

Tel No



Fax No



E-Mail address

**K) CERTIFICATION PARTICULARS**

I declare that all the particulars furnished on this form is true and correct.

Signature or Thumbprint of Member

Declared and signed before me

Commissioner of Oaths

Commissioner Stamp

Date

Date