Member withdrawal request form

Contact us
Tel: 0800 12 CARE (2273) • PO Box 653418, Benmore 2010 • www.libcare.co.za

Libcare Medical Scheme (referred to as Libcare or the Scheme), registration number 1197, is a not-for-profit entity, registered with the Council for Medical Schemes as a closed membership scheme which provides cover for eligible full-time permanent staff members and eligible retirees of the Liberty Group, and their eligible dependants.

Discovery Administration Services (Pty) Ltd (referred to as the Administrator), registration number 2004/006809/07, is a separate company to Libcare, and is accredited by the Council for Medical Schemes to provide administration services to medical schemes, including Libcare and its members.

How to complete this form

1. To be completed and returned to your Payroll Administrator.
2. This form needs to be completed in order to withdraw the registration of a dependant and/or the Principal Member.
3. Please print clearly using CAPITAL letters and one character per block.
4. To avoid administrative delays, please make sure this application is completed in full.

1. Employer contact details (to be completed by employer)

Please give us the details of the person who should receive correspondence on the withdrawal process:

Payroll Administrator name

Designation

Employer telephone number

Fax

Pay point code

Employee number

E-mail address

Employer signature

Date D D M M Y Y Y Y

2. Details of Principal Member

Member name

Membership number

Employee number

Contact number

E-mail address

Signed at

Principal Member signature

Date D D M M Y Y Y Y

Please do not sign an incomplete application form

3. Withdrawal

Membership withdrawal

Dependant withdrawal

Effective date D D M M Y Y Y Y

If a dependant withdrawal please complete section below

Please note

No backdated withdrawals are allowed. All withdrawals need to be submitted a month in advance. If submitted mid-month, the full contribution will be charged for the month.

Initials and surname	Date of birth/ID number	Effective date

Reason for withdrawal (please tick)

Self-supporting ☐ Divorce ☐

Marriage ☐ Over age dependant ☐

Transfer to a new Medical Scheme ☐

☐ Other (please specify)

4. Banking details (for Medical Savings Facility refund, if applicable)

Note: The Medical Scheme Act requires that your Medical Savings Facility balances must be transferred to your next Medical Scheme. Only in the event that you are not joining a new Medical Scheme or if the new Medical Scheme does not have a savings option, may a cash refund be made to you. If you are joining another Medical Scheme within the next four months, kindly complete the details of that Scheme below or advise us of such details as soon as they are known.

New Medical Scheme Details

Membership Number

New Medical Scheme Details

Date Joined D D M M Y Y Y Y

Note: Only complete the section below if you are not joining another Medical Scheme and the funds in the Medical Savings Facility needs to be refunded to you.

I am not joining another Medical Scheme, therefore, please pay the balance of my Medical Savings Facility to the following bank account.

Bank account owner (Mark with an X) Principal Member ☐ Third party ☐

Bank name

Full name of account holder

Branch name

Account number Account type Current ☐ Savings ☐ Transmission ☐

Please note: If the above bank account is not yours, please insert the third party's ID number

Third party's ID number

Signature of account holder

Please do not sign an incomplete application form.

Signature of Principal Member

Please do not sign an incomplete application form.

Please note:

1. Submit the following with this form: Copy of ID and Bank statement/letter of confirmation from the bank.
2. Credit card accounts are not accepted and you can only use a South African bank account.
3. If you are using someone else's bank account, the account holder must sign above to confirm this.

5. Contact details for future correspondence

Email address

Postal address (Post collected from post box, suite or private bag)

PO Box | Private bag | Box number

Suite | Postnet suite | Number

Suburb | Postal code

6. Declaration by Principal Member

When you sign this application, you confirm that all the information provided is correct.

Principal Member signature

Date D D M M Y Y Y Y

Please do not sign an incomplete application form.