Parc du Cap, 7 Mispel Road, Bellville 7530
PO Box 5324 Cape Town 8000
Enquiries: Tel 021 480 4610 or 0800 001 607 Fax 021 480 4969
Email: enquiries@bpmas.co.za
www.bpmas.co.za

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CONTINUATION MEMBERSHIP APPLICATION (POST-RETIREMENT)

Please complete all sections clearly and accurately.

MEMBER INFORMATION

Full Name: _____ Membership Number: _____

ID/passport number: _____ Contact Number: _____

Email address: _____

EMPLOYMENT STATUS

Employer Name: _____ Retirement Date: _____

CONTINUATION MEMBERSHIP REQUEST

I, the undersigned, hereby request to continue my medical aid membership as a continuation member following my retirement from active employment.
I understand and acknowledge the following:

- My current medical aid membership is through my employer.
- Upon retirement, I wish to retain uninterrupted medical aid coverage.
- I agree to assume full/partial responsibility for my monthly contributions as a continuation member, which is to be confirmed in the Employer Section below by my current employer. Failure to do so will result in my membership being suspended or terminated as per the Scheme's Rules.

Membership Continuation Effective Date: _____

DECLARATION

I confirm that the information provided above is true and correct. I understand that any changes to my membership status or contribution method must be communicated in writing to the medical aid administrator.

Member signature _____ **Date** _____

EMPLOYER DECLARATION

This section must be completed by the employer to confirm whether the above-mentioned retired employee will receive a subsidy towards their medical aid contributions upon continuation of their membership.

☐ Yes, the company will continue to subsidise the employee's medical aid contributions post-retirement.

Subsidy: Percentage: _____ OR Amount: R _____ Duration of Subsidy: _____

☐ No, the company will not provide a subsidy towards the employee's medical aid contributions post-retirement.

Authorised Payroll Name _____ **Payroll signature** _____ **Date** _____

Please submit the completed form and any supporting documents to: **membership@bpmas.co.za**

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BANKING DETAILS FORM

This form is used to collect or update banking information for payment or debit purposes.
Please complete all sections clearly and accurately.

MEMBER INFORMATION

Full Name: _____ Membership Number: _____

ID/passport number: _____ Contact Number: _____

Email address: _____

BANKING DETAILS

(Do not submit credit card information. The Scheme Administrator is not authorised to collect or retain such details.)

Account Holder Name: _____ Bank Name: _____

Branch Code: _____ Account Number: _____

Account Type: Current/Cheque ☐ Savings ☐ Transmission ☐

Specify your choices by ticking the relevant boxes.

☐ I hereby instruct and authorise the Scheme and it's Administrators to debit my account for **MEDICAL CONTRIBUTIONS.**

☐ I hereby instruct and authorise the Scheme and it's Administrators to use this account for all **CLAIM REFUNDS.**

Please attach the following supporting documents:

- Copy of the account holder's ID
- Proof of banking details (e.g., bank statement or confirmation letter with stamp)

Please submit the completed form and supporting documents to: **membership@bpmas.co.za**

- I hereby confirm that the above banking details are correct.
- I hereby authorise the Scheme and it's Administrators to use this information for the purpose of processing payments or debits as indicated.
- I understand that this authority may be cancelled by me/us by giving 30 days written notice.
- I understand that the Scheme and it's Administrators will not be held responsible if notification of change in banking details is not provided in the above specified time.
- I understand that the Scheme or Administrator will not accept liability for any payment made into the incorrect bank account.
- If the account is held in the name of another individual, the account holder must sign below to grant permission for deductions and provide a copy of their ID.

Member signature

_____

Date

_____

Account holder's signature

_____

Date

_____