

# Termination of Dependant/Membership Form 2026



**Contact us**

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## How to complete the form

- This form is to be completed by members who wish to advise the Scheme of termination of dependant and/or membership
- Three months' notice is required for termination
- Please print clearly or complete digitally
- Please mark with an X where necessary
- Please submit the completed and signed form via email to [membership@medipos.co.za](mailto:membership@medipos.co.za). Active members must submit the form to the HR office.

### 1. SECTION A – MAIN MEMBER’S DETAILS

Surname

Name

Membership number

Email

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

PO Box       Private Bag      Box number

Suite       Postnet Suite      Number

Suburb

City  Postal code

### 2. SECTION B – DEPENDANT AND/OR MEMBERSHIP TERMINATION DETAILS

Please tick this box if the whole membership must be terminated  Effective date of termination

Please complete the table below for dependants that must be terminated

Dependant number	Dependant name and surname	Dependant's ID/passport number
<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"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

### 3. SECTION C – REASON/S FOR TERMINATING MEMBERSHIP

Moving to a new medical scheme	<input type="checkbox"/>
If yes, name of the new medical scheme and option	
Married and moving onto spouse's medical scheme	<input type="checkbox"/>
Contributions no longer affordable	<input type="checkbox"/>
Not satisfied with benefits	<input type="checkbox"/>
Not satisfied with service	<input type="checkbox"/>
No longer employed	<input type="checkbox"/>
Reason for employment ending (e.g. resigned, retrenched, retired)	
Moving overseas	<input type="checkbox"/>
Other (Please specify)	

### 4. SECTION D – BANKING DETAILS

Please provide your banking details, in the event the Scheme should wish to refund you any credits due as a result of the following:

- Any provider accounts that you may have settled in cash
- Contribution overpayments
- Refunds on positive savings (only applicable on Option B). This only needs to be provided if you are not joining a new medical scheme option offering a savings account.

If a third party's account details are used, please provide a copy of their ID.

Bank name	<input type="text"/>						
Branch name	<input type="text"/>	Branch code	<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>
Account number	<input type="text"/>	Account type	Current <input type="checkbox"/>	Transmission <input type="checkbox"/>	Savings <input type="checkbox"/>		
Account holder name	<input type="text"/>						

### 5. SECTION E – AUTHORISATION

Please specify the termination date of your membership

(Please note that in terms of the Scheme Rules, the Scheme requires a minimum of three months' notice to terminate your membership)

5.1. Please note that upon termination of your membership, MEDiPOS will retain your Personal and Health Information in order to provide all termination services to you. We will further retain and archive your Personal and Health Information for as long as is required by law. While retaining and archiving your Personal and Health Information as such, we will continue to take appropriate reasonable technical and organizational measures to protect the integrity and security of your Personal and Health Information. This includes taking reasonable steps to protect your Personal and Health Information that we continue to retain and archive from misuse, loss, interference, unauthorised access, modification or unauthorised disclosure

5.2. Where we are no longer required to retain and archive your Personal and Health Information, we will destroy or de-identify the information.

Main member's signature	<input type="text"/>	Date	<input type="text"/>						
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