CELLMED HEALTH
MEDICAL FUND

MEMBERSHIP AMENDMENT FORM

Name of Employer / Account Holder	
Authorised Signatory	
Member's Name	
Membership Number	
Cover Commencement Date	

I wish to **ADD / TERMINATE / AMEND** my membership / beneficiary of the under mentioned
[Tick where applicable and attach copies of ID, Passport or Birth Certificate of new member]

Name	DOB	Relationship	ID Number	Add	Amend	Terminate

Reason(s) for Termination / Amendment / Addition [Tick Applicable]

If changing packages please indicate

Current Package | New Package

Medical History [To be completed only when adding or amending membership]

Name of member / beneficiary	
Condition	
Treatment Administered	
Name of Doctor	
Doctor's Telephone Number	

Date | Signature