AFFINITY HEALTH

Consolidated Amendment Form

Principal Member Personal Information

Surname:		Full Name:	
ID/Passport Number:		Date of Birth:	
Gender:	☐ Female ☐ Male	Marital Status:	☐ Single ☐ Married ☐ Divorced ☐ Widowed
Company Address:		Employee Number:	
Physical Address:		Home Language:	
Preferred Delivery Address:			
Contact Number:	Cell:	Work:	Emergency:
Email Address:		Weekly/Monthly Wages:	
Ethnic Group:	☐ White ☐ Black ☐ Coloured ☐ Indian ☐ Other	**Note:** Ethnicity reporting is required by the Council for Medical Schemes.	

Adding Dependants

Spouse:		ID/Passport Number:	
Ethnic Group:	☐ White ☐ Black ☐ Coloured ☐ Indian ☐ Other	Gender:	☐ Female ☐ Male
Smoker?		Weight?	
Dependant 1:		ID/Passport Number:	
Ethnic Group:		Gender: ☐ Female ☐ Male	Relationship:
Dependant 2:		ID/Passport Number:	
Ethnic Group:		Gender: ☐ Female ☐ Male	Relationship:
Dependant 3:		ID/Passport Number:	
Ethnic Group:		Gender: ☐ Female ☐ Male	Relationship:
Dependant 4:		ID/Passport Number:	
Ethnic Group:		Gender: ☐ Female ☐ Male	Relationship:
Dependant 5:		ID/Passport Number:	
Ethnic Group:		Gender: ☐ Female ☐ Male	Relationship:

Removing Dependants

Spouse:		ID/Passport Number:	
Dependant 1:		ID/Passport Number:	
Dependant 2:		ID/Passport Number:	
Dependant 3:		ID/Passport Number:	
Dependant 4:		ID/Passport Number:	
Dependant 5:		ID/Passport Number:	

Package Options: Policy Options and Rates

(Indicate the amount of dependants in the allocated space) (Not more than 1 (one) Spouse shall be covered)

Healthcare Packages:	Affinity Reef	Chrome	Bronze	Delta Max	Silver Max	Gold Max	Platinum Max	Titanium Max
Principal Member:	R399 ☐	R509 ☐	R659 ☐	R739 ☐	R929 ☐	R1 019 ☐	R1 259 ☐	R1 449 ☐
Spouse:	R369 ☐	R469 ☐	R609 ☐	R669 ☐	R839 ☐	R939 ☐	R1 159 ☐	R1 329 ☐
Adult Dependant:	R369 ☐	R469 ☐	R609 ☐	R669 ☐	R839 ☐	R939 ☐	R1 159 ☐	R1 329 ☐
Child Dependant:	R219 ☐	R309 ☐	R389 ☐	R439 ☐	R499 ☐	R589 ☐	R719 ☐	R829 ☐
Insurance Packages:								
Principal Member:	R45 ☐	R62 ☐	R91 ☐	R130 ☐	R113 ☐	R164 ☐	R170 ☐	R175 ☐
Spouse:	R			R51 ☐		R51 ☐	R56 ☐	R63 ☐
Total Premium:			**Inception Date:**					

Declaration

I hereby request and authorise you to deduct from my salary the above mentioned amount or any other variable amount pertaining to this agreement. These deductions from my salary shall be treated as though they have been authorised by me personally. By completing this form, I hereby acknowledge that I have willingly consented to the collection, processing and storing of my personal information by Affinity Life Limited.

Principal Member Signature: _____ Date: DD | MM | YYYY