

DISCOVERY: CANCELLATION OF MEMBERSHIP

Member Initials and Surname: _____

Member / ID number: _____

Employer Name: _____

Date: ____/____/202__

I hereby request DISCOVERY to cancel my membership effective ____/____/202__

Reason for cancellation: _____

I am aware that Discovery needs 30 days calendar notice and that if I cancel during the year, it could create a clawback, which means I may owe the medical scheme money. I will be responsible to ensure that I know what this amount is.

Signature of Principal Member

Date Signed

Signature - Medical Administrator

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Date:

