2026 PLAN SELECTION FORM
WORKING MEMBERS AND PENSIONERS

Please complete all the sections in ink and block letters **only** if you wish to change your plan.

YOU HAVE THREE METHODS TO MAKE YOUR PLAN SELECTION

Email the completed form to **membership@transmed.co.za**.

Post the completed form to Transmed Membership Department, PO Box 2269, Bellville 7535.

Call the customer service department on **0800 450 010**. Remember to have your membership and identity numbers handy. Please do not submit this form if you have already changed your plan telephonically.

You may only change your plan once a year. This form must reach the Fund by 31 December 2025. If we do not receive your form by this date, your plan change will not be effected.

A. MEMBER DETAILS

Membership number _____ Current plan _____

Title _____ First name/names _____

Surname _____

Name of bank _____ Bank account number _____

Branch code _____ Type _____

Please attach a copy of your ID and a bank statement or a stamped letter from your bank (not older than three months).

Postal address _____

_____ City or town _____ Postal code _____

Telephone number (Work) _____ Telephone number (Home) _____

Cell phone number _____

Email address _____

The information above is required to confirm your plan change and to update our records. Note: All personal information recorded on this form and submitted to Transmed Medical Fund will be processed as set out on this form and as stipulated in Transmed's privacy policy.

B. PLAN SELECTION FOR 2026

You may choose only one plan. Please indicate your choice with an 'X' in the appropriate box.

I hereby confirm that I wish to change to the following plan with effect from 1 January 2026:

☐ **Link plan** (Universal Healthcare Network)

☐ **Select plan**

Member's initials and surname
_____

Date
DD/MM/YYYY

Member's signature
_____