transmed MEDICAL FUND

FOR ALL OUR PEOPLE

AFFIDAVIT FOR CONFIRMATION OF INCOME

It is important that all sections of this form be completed in full. Once the form has been completed, it should be returned to **membership@transmed.co.za**. You may also post it to Transmed Membership, PO Box 2269, Bellville 7535. If you require assistance in completing this form, please call **0800 450 010**.

PLEASE COMPLETE THE FORM IN BLOCK LETTERS.

MEMBERSHIP NUMBER

1. PERSONAL DETAILS OF PRINCIPAL MEMBER (COMPULSORY TO COMPLETE)

Title | Initials | Identity/Passport number

Surname

First names

Contact numbers: Home: | Work: | Cell phone:

Email address

Residential address

Code

Postal address

Code

2. AFFIDAVIT – PROOF OF INCOME

I declare that my monthly income is **R** and consists of the following:

☐ Monthly pension ☐ Annuities ☐ Investments ☐ Other (please specify): _____

I, FULL NAME AND SURNAME _____, confirm that all of the information is true in every respect.

I understand and agree that the consequence of submitting inaccurate information could result in the:

- forfeiture of all benefits of the Fund
- refunding in full all amounts for benefits/services paid on my behalf by Transmed
- waiving of my right to claim a refund for any contributions paid by me to Transmed.

Signed at **on** DD/MM/YYYY

Signature of member **Commissioner of Oaths**

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Customer service department: **0800 450 010**
Email: **membership@transmed.co.za**
Website: **www.transmed.co.za**