CONTACT INFORMATION OF DEPENDANTS
18 YEARS AND OLDER

It is a legal requirement for the Fund to have the contact information of your registered dependants who are 18 years and older on record. 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. MEMBER INFORMATION

Title   Initials   Gender [ ] Male [ ] Female

Surname

First names

Identity/Passport number   Date of birth DD/MM/YYYY

Contact numbers   Home: Race* [ ] African [ ] Coloured [ ] Indian/Asian
   Work: [ ] White [ ] Other [ ] Do not wish to disclose
   Cell phone:

Email address

Residential address

   Code

Postal address

   Code

2. INFORMATION OF DEPENDANTS 18 YEARS AND OLDER

Dependant 1

Title   Initials   Gender [ ] Male [ ] Female

Surname

First names

Identity/Passport number   Date of birth DD/MM/YYYY

Relationship to member   (e.g. son)   Race* [ ] African [ ] Coloured [ ] Indian/Asian

Contact number   [ ] White [ ] Other [ ] Do not wish to disclose

Email address

Residential address

   Code

Postal address

   Code

*Optional information required by the Council for Medical Schemes (CMS) for statistical purposes.

2. INFORMATION OF DEPENDANTS 18 YEARS AND OLDER (CONTINUED)

Dependant 2

Title ____ Initials ____ Gender ☐ Male ☐ Female

Surname ____

First names ____

Identity/Passport number ____ Date of birth DD/MM/YYYY

Relationship to member ____ (e.g. son) Race* ☐ African ☐ Coloured ☐ Indian/Asian

Contact number ____ ☐ White ☐ Other ☐ Do not wish to disclose

Email address ____

Residential address ____

____ Code ____

Postal address ____

____ Code ____

Dependant 3

Title ____ Initials ____ Gender ☐ Male ☐ Female

Surname ____

First names ____

Identity/Passport number ____ Date of birth DD/MM/YYYY

Relationship to member ____ (e.g. son) Race* ☐ African ☐ Coloured ☐ Indian/Asian

Contact number ____ ☐ White ☐ Other ☐ Do not wish to disclose

Email address ____

Residential address ____

____ Code ____

Postal address ____

____ Code ____

Dependant 4

Title ____ Initials ____ Gender ☐ Male ☐ Female

Surname ____

First names ____

Identity/Passport number ____ Date of birth DD/MM/YYYY

Relationship to member ____ (e.g. son) Race* ☐ African ☐ Coloured ☐ Indian/Asian

Contact number ____ ☐ White ☐ Other ☐ Do not wish to disclose

Email address ____

Residential address ____

____ Code ____

Postal address ____

____ Code ____

*Optional information required by the Council for Medical Schemes (CMS) for statistical purposes.

Dependant 5

Title [ ] Initials [ ] Gender [ ] Male [ ] Female

Surname [ ]

First names [ ]

Identity/Passport number [ ] Date of birth [DD/MM/YYYY]

Relationship to member [ ] (e.g. son) Race* [ ] African [ ] Coloured [ ] Indian/Asian

Contact number [ ] [ ] White [ ] Other [ ] Do not wish to disclose

Email address [ ]

Residential address [ ]

[ ] Code [ ]

Postal address [ ]

[ ] Code [ ]

*Optional information required by the Council for Medical Schemes (CMS) for statistical purposes.

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

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