OCSA Care

Workers' healthcare is our business

EMPLOYEE APPLICATION FORM

01 OPTIONS

OCSACare Silver: ☐ OCSACare Silver Plus: ☐ OCSACare Gold : ☐

02 EMPLOYEE DETAILS

Company Name:

Branch Name:

Employee Number: ID No/Passport No:

Date of Birth: D D M M Y Y Y Y

Mr: ☐ Mrs: ☐ Ms: ☐ Initials: Surname:

First Name(s): Male: ☐ Female: ☐

Work Tel No: Cell No:

I would like to join: 0 1 M M Y Y Y Y
(1st of the month)

03 Hand in this OCSACare application form to your HR Manager or your Supervisor.

I hereby acknowledge that the above is true and correct and I accept the terms and conditions of this option.
Monthly contributions are payable by the first of every month.

I give permission to share any information to healthcare service providers in whose care I am or any other person who has information about my health that is required for administrative and statistical purposes, provided such information shall be treated as confidential at all times.

Signature: Date:

FOR OFFICE USE ONLY

Broker Code: Mem No: