NATIONAL TREASURY
Government Employees Pension Fund (GEPF)

MEDICAL SCHEME MEMBERSHIP – Z583

GEPF USE ONLY - GEPF STAMPS

BAR CODE

Private Bag x63
Pretoria
SOUTH AFRICA
0001

34 Hamilton Street
Arcadia Pretoria

Tel No : (+27) (0) 12 319 1911
Fax No : (+27) (0) 12 326 2507
Call Centre : (+27) (0) 12 319 1000
E-mail : enquiries@gepf.co.za
WebSite : www.gepf.co.za

PARTICULARS OF MEDICAL SCHEME MEMBERSHIP

This form enables the GEPF to successfully process the application for continued Medical assistance or to indicate a change in Medical Scheme Particulars.

COMPULSORY ATTACHMENTS: See section B.

A) TYPE OF APPLICATION - Please select only one option

☐ 1. Application for continued Medical Assistance after Retirement/Death in Service (Resolution 3 of 1999 and Resolution 1 of 2006) (Compulsory items: B,D,E,F,G,H,I,J and K. C in case of death)

☐ 2. Continued Membership of Medical Scheme - Change of Medical Scheme Particulars (Compulsory items: B,D,E,F,G,H and K)

☐ 3. Application of Widow / Widower for continued Membership of Medical Scheme (Compulsory items: B,C,D,E,F,G and K)

B) COMPULSORY ATTACHMENTS

All copies of ID documents should be clear, and should not be older than 6 months.

1. Certified copy of ID of the main member of the Medical scheme. ☐
2. Proof of all the dependants registered on your medical scheme. Certified copy of ID and or birth certificate. ☐
3. Membership Certificate from your medical scheme. ☐
4. Member Death Certificate (if applicable) ☐
5. Please include previous medical scheme certificate(s). ☐

Only applicable to Type 2 Applications:

- Copy of last Salary Advice ☐
- Completed Z894 - Bank particulars ☐
- Service Certificate ☐

C) PERSONAL PARTICULARS OF DECEASED MEMBER

Pension Number

Surname

First Name

Middle Name

Maiden Name

Title Init D.O.B ID No

Date of Death Marital Status ☐ Married ☐ Unmarried ☐ Widow/er ☐ Divorced ☐ Life Partner

D) PERSONAL PARTICULARS OF APPLICANT

Pension Number

Surname

First Name

Middle Name

Maiden Name

Title Init D.O.B ID No

Income Tax No Marital Status ☐ Married ☐ Unmarried ☐ Widow/er ☐ Divorced ☐ Life Partner

E) CONTACT PARTICULARS OF APPLICANT

Postal Address

Postal Code

Tel No

E-Mail

Residential Address

Postal Code

Cell No

ALL PAGES OF THIS FORM MUST BE COMPLETED IN ORDER FOR THIS FORM TO BE VALID AND THE MEMBER OR PENSIONER AND COMMISSIONER OF OATHS MUST INITIAL THIS PAGE.

Member/Pensioner initial

Commissioner of Oaths initial

Pension Number

F) PARTICULARS OF DEPENDANTS - For any dependant registered on your medical scheme

	Surname	First Name	ID No / Passport number	Type *
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

* 1-Spouse 2-Child 3-Disable 4-Student 5-Life Partner 7-Mother 8-Father 9-Grandchild A-Sister B-Brother

G) PARTICULARS OF MEDICAL SCHEME

The Medical Scheme details refer to the current and new medical scheme

Medical Scheme Name

Medical Scheme Number

Would you like to continue your membership? ☐ Yes ☐ No

Date of Benefit Membership Commencement Date

H) PARTICULARS OF PREVIOUS MEDICAL SCHEME

Date on which membership was terminated

Medical Scheme Name

Medical Scheme Number

I) CHOICE FOR MEDICAL BENEFIT UPON RETIREMENT / DEATH

A single choice between Option A or Option B is compulsory - Please indicate clearly

1. OPTION A - Continued State Subsidised Membership

Subject to 12 months continued membership of a registered medical fund on the last day of service and previous government service exceeding: ☐

- 15 Years in respect of retirement
- 10 years in respect of medical discharge

Employer Name

Start Date End Date

Employer Name

Start Date End Date

Employer Name

Start Date End Date

Employer Name

Start Date End Date

OR

2. OPTION B - Gratuity Payment (Once-off cash amount)

Subject to 12 months continued membership of a registered medical fund on the last day of service only if less than: ☐

- 15 Years in respect of retirement
- 10 years in respect of medical discharge

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Member/Pensioner initial Commissioner of Oaths initial

Pension Number

J) TO BE COMPLETED BY THE LAST EMPLOYER DEPARTMENT

State Contribution to member medical aid on last day of service

Last day of employment

Reason for retirement

Service record in government departments or related institutions. All periods of service must be furnished:

From	To	Department or Institution

I certify that all particulars in this form are true and correct.

Official Date Stamp of Employer

Signature 1

Designation

Surname of Employer Representative

Tel No

Fax No

E-Mail address

K) CERTIFICATION PARTICULARS

I declare that all the particulars furnished on this form is true and correct.

Signature or Thumbprint of Member

Date

Declared and signed before me

Commissioner of Oaths

Date

Commissioner Stamp