HERITAGE HEALTH®
LIVE BOLDLY

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TERMINATION FORM

Membership Number

Section A: Applicant Details

Title		Initials		Full Names										
Surname														
Postal Address														
Telephone Number	H	Code			W	Code								
Cellphone Number					Fax Number									
Email Address														
Date of Birth	D	D	M	M	Y	Y	Y	Y	Age		ID / Passport Number			
Gender	M		F											
Marital Status		Single		Married		Divorced		Widowed						
Termination Date	D	D	M	M	Y	Y	Y	Y						

Section B: Reason for Termination

Acknowledgment and declaration: I hereby give one calendar month notice period by signing this termination form and certify that the information provided herein is true and correct.

Financial constraints		Deceased		Immigrating		Service Challenges	
Joining spouse's/partner's medical aid fund		Fund name					
Joining another medical aid fund		Fund name					
Other (please specify)							

Section C: Declaration and Acknowledgement

1.	I acknowledge having read and I understand the **significance of the importance of the correct completion of the information requested** in this application form pertaining to me and my dependants. **I declare all entries made on this form to be true and correct and that I am not aware of any circumstances which might affect the risk on my health or any of my dependants.** Should there be any non-disclosure or misrepresentation, I understand and accept that my membership may be terminated and that I may forfeit my contributions. Heritage Health Medical Aid Fund has the right to claim any costs incurred in respect of my non-disclosure or misrepresentation.
2.	Should any of my or my dependant(s)' circumstances be altered subsequent to the date of completing this application, prior to or after the acceptance of my membership by Heritage Health Medical Aid Fund, I undertake to notify the Fund immediately. I acknowledge that failure to do so may lead to the termination or amendment of the terms and conditions of my membership.
	I understand that any changes to this document as well as membership status of any of myself or any of my beneficiaries will require the completion of the necessary forms.
3.	I understand and agree that it is my responsibility to ensure that the monthly contribution to be paid for my membership is paid by no later than the seventh day of each month upfront (in advance) whether such payment is undertaken by debit order or by my employer or any other person who pays on my behalf. I accept that failing to pay the applicable monthly contribution will result in the suspension of all benefits. Failing to pay for contributions for three consecutive months will automatically terminate my cover.
4.	I authorise the obtaining of any personal medical information relating to me or any of my dependants from a treating physician who has attended to or examined me or my dependants and which may be required in respect of this application or any future claims submitted by me.
5.	It is further agreed and understood that, notwithstanding any statements made to the contrary by any person, membership will not commence and no liability whatsoever will attach to Heritage Health Medical Aid Fund, unless express written notice of acceptance of risk is given by the Fund.
6.	I authorise and permit Heritage Health Medical Aid Fund to take all reasonable steps to verify the information provided by me in this application form.
7.	I further accept that the provisions of any declaration made have been read and understood by me and will also apply mutatis mutandis to and form part of this application.
8.	I understand and accept that this declaration and my application form constitute the basis of my contract with Heritage Health Medical Aid Fund. No oral representations, inducement, statements or promises by or on behalf of any party, and not contained in the application form, shall be relied upon.
9.	I agree to be bound by the terms and conditions of cover under Heritage Health Medical Aid Fund.
10.	I hereby consent that all my contact details may be used by Heritage Health Medical Aid Fund for the distribution of information.
11.	I agree that any payment accompanying the application shall be a deposit only and I understand that any cover will only commence once I receive the membership card and any conditions pertaining to the cover.
12.	I declare that no material fact(s) have been withheld, misstated or concealed by myself or in respect of my beneficiaries and that I herewith unequivocally undertake to disclose all material facts prior to acceptance of the risk and I agree that any misrepresentation, misstatements and / or omission(s) of any material information, particularly in so far as it relates to disclosure of medical information pertinent to risk, will render my membership null and void.
13.	I hereby acknowledge that Heritage Health Medical Aid Fund does not extend credit for myself or my dependants whilst being a members of Heritage Health Medical Aid Fund, therefore upon termination of membership of Heritage Health Medical Aid Fund, all outstanding payable credit and interests may be charged on all amounts owing to Heritage Health Medical Aid Fund.
14.	I acknowledge that in the event of any modification or variation of this standard form, Heritage Health Medical Aid Fund will regard this form as being invalid and of no force and effect.
15.	I understand that any changes to this document as well as membership status of any of myself or any of my beneficiaries will require the completion of the necessary forms.
16.	I hereby acknowledge that I understand that the product selected has an overall annual limit with applicable sub limits.
17.	I understand and agree to all the above.

Signed at _____ on this _____ day of _____ 20____

_____
Signature of main member

Company Stamp