CHANGE OF HEALTH CARE COVER WAIVER FORM

SECTION A: EMPLOYEE DETAILS

Employee Name and Surname	
Position	
Grant / Department	
Employee Start Date / Date Engaged	D D M M Y Y Y Y

SECTION B: ACKNOWLEDGEMENT OF HEALTH CARE COVER CHANGE

Please tick (✓) as appropriate.

	I acknowledge that:
☐	I am aware and consent to a double deduction that will occur if I am submitting the form after the payroll cut-off date.
☐	I am aware that requests for membership start in the following month if I do not consent to a double deduction and waives any employer responsibility in terms of my healthcare for the month I am uncovered.
☐	I understand and fully accept the risks associated with downgrading my plan type or completely moving off medical scheme cover and onto the primary healthcare product.

I also declare that I have read and understand the contents of the above and fully acknowledge the implications and risks of downgrading from a medical scheme to a primary health care product. Therefore, I cannot hold the Company liable for **any** personal medical expenses, whatsoever, incurred during the course of my employment with the Company.

SECTION C: AUTHORISATION

Declared by (Full Name and Surname)	
Date	D D M M Y Y Y Y
Signature	
HR Representative (Full Name and Surname)	
Date	D D M M Y Y Y Y
Signature	