

# Option change form

**Contact details**

Tel: 0860 103 933 • PO Box 652509, Benmore 2010 • [www.lahealth.co.za](http://www.lahealth.co.za)

**Who we are**

LA Health Medical Scheme (referred to as 'the Scheme'), registration number 1145, is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). Discovery Health (Pty) Ltd takes care of the administration of your membership for the Scheme.

Please return the completed form to your employer, pension fund or broker by the 30 November 2024, to make sure your request is captured.

**1. Member's details**

|               |                      |                      |                      |                      |
|---------------|----------------------|----------------------|----------------------|----------------------|
| Member name   | <input type="text"/> |                      |                      |                      |
| Telephone (H) | <input type="text"/> | <input type="text"/> | Telephone (W)        | <input type="text"/> |
| Cellphone     | <input type="text"/> | <input type="text"/> | Fax                  | <input type="text"/> |
| Email         | <input type="text"/> |                      |                      |                      |
| Member number | <input type="text"/> | Payroll number       | <input type="text"/> |                      |

I want to change my Benefit Option to:    LA KeyPlus     LA Active     LA Focus     LA Core     LA Comprehensive

with effect                   

Please complete by providing details of your nominated KeyCare GP, if you have selected the LA KeyPlus Benefit Option.

|                   | Name | GP name | Practice number |
|-------------------|------|---------|-----------------|
| Main Applicant    |      |         |                 |
| Spouse or partner |      |         |                 |
| Dependant One     |      |         |                 |
| Dependant Two     |      |         |                 |
| Dependant Three   |      |         |                 |

**Reason for change**

|                      |
|----------------------|
| <input type="text"/> |
| <input type="text"/> |
| <input type="text"/> |

|                  |                      |      |                      |
|------------------|----------------------|------|----------------------|
| Member signature | <input type="text"/> | Date | <input type="text"/> |
|------------------|----------------------|------|----------------------|

**Please do not sign an incomplete application form.**

Please note: If you are not paying the full contribution to the Scheme via debit order from your own bank account, LA Health Medical Scheme will not accept any changes to your membership without approval from your Municipal Salary Office, and / or pension fund.

## 2. Employer or pension fund approval

|           |                      |                      |                      |                      |                      |                      |                      |                      |                      |                      |                      |                      |                              |                             |                      |                      |
|-----------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|------------------------------|-----------------------------|----------------------|----------------------|
| Name      | <input type="text"/> |                      |                      |                      |                      |                      |                      |                      |                      |                      |                      |                      |                              |                             |                      |                      |
| Telephone | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | Approved             | Yes <input type="checkbox"/> | No <input type="checkbox"/> |                      |                      |
| Signature | <input type="text"/> |                      |                      |                      |                      |                      |                      |                      | Date                 | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/>         | <input type="text"/>        | <input type="text"/> | <input type="text"/> |

|                |
|----------------|
| EMPLOYER STAMP |
|----------------|

For further details email [lahealthadmin@lahealthms.co.za](mailto:lahealthadmin@lahealthms.co.za).