

TERMINATION FORM

Tel.: +264 61 2999 000 • Fax: +264 61 2999 112



Renaissance Health
Medical Aid Fund

Member Name:

Membership No.:

Employee No.:

Company Name:

Termination Date:

0	1	M	M	Y	Y	Y	Y
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Note: One month notice in advance required.

Reason for Termination (**Compulsory**):

Resigned from Employer

Joined another scheme

Deceased/Disabled

Scheme name:

Other (*Please stipulated reason*)

Principal Member:

Signature

Date

0	1	M	M	Y	Y	Y	Y
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Member
Contact Details:

HR Department: (*Not applicable for Private members*)

CB Number

Print Name:
(Official/HR Officer)

Signature:
(Official/HR Officer)

Date

0	1	M	M	Y	Y	Y	Y
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Company Stamp

Administered by Prosperity Health