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hosmed medical scheme care for life

DOCTOR CHOICE FORM

PLEASE PRINT IN CAPITAL LETTERS. USE A BLACK PEN ONLY. PLEASE ENSURE THAT THE MEMBER AND DEPENDANT DETAILS ON THIS FORM ARE THE SAME AS ON THE APPLICATION FOR MEMBERSHIP FORM.

Medical aid no.		Hosmed Step

SECTION A: MEMBER AND DEPENDANT DETAILS

	Principal member	Dependant 1	Dependant 2	Dependant 3	Dependant 4
Surname					
First name					
Identity no.					
Date of birth					
Gender (M / F)					
Address					
Tel no.					
Name of doctor of choice					
Doctor's address					
Doctor's Tel no.					
Practice no. (office use)					

If insufficient for number of dependants, please complete a second form

Signature

Date