DUPLICATE MEMBERSHIP CARD

APPLICATION DUPLICATE MEMBERSHIP CARD

AECI® MEDICAL AID SOCIETY

Please provide the information requested below and mail, or hand deliver the completed form to one of the following Medscheme regional offices:

ROODEPOORT
(Scheme name)
Membership Department
P O Box 1101
Florida Glen
1708

DURBAN
(Scheme name)
Membership Department
P O Box 2825
Durban
4000

PORT ELIZABETH
(Scheme name)
Membership Department
P O Box 3711
North End
6056

TO BE COMPLETED BY THE PRINCIPAL MEMBER

Membership number

Scheme name

Title

Initials

Surname

Telephone number (work)
c o d e

Cellular number

Telephone number (home)
c o d e

Postal address (only provide street address if the Post Office delivers mail to you)
c o d e

E-mail address

Number of cards requested

Reason for request:

☐ Spouse/Partner ☐ Adult/Special Dependant ☐ Student/Child Dependant ☐ Late notification of Change of Address

☐ Lost/Stolen Other _____

_____
Principal member's signature

Date d d m m y y y y