



# RESOLUTION

## health Medical Scheme

### INTERNATIONAL TRAVEL COVER FORM

**This application form must be received at the Scheme within one week following the date on which it was signed. Failure to do so will result in this application being null and void. Incomplete application forms will not be accepted. (Note: Please complete all sections in BLACK ink)**

Membership Number																								
Surname																			Title					
First Name(s) <i>(in full)</i>																			Initials					
ID Number							Date of Birth	D	D	M	M	Y	Y	Y	Y	Gender	M	F						
Passport Number							Overseas Contact No:																	
Email Address:																								
Cell phone Number:							Fax Number:																	
Destination:																								

Details of Person(s) Traveling:

Title	Initials	Surname	Date of birth				ID Number	Gender				
			D	D	M	M	Y	Y	Y	Y	M	F
			D	D	M	M	Y	Y	Y	Y	M	F
			D	D	M	M	Y	Y	Y	Y	M	F
			D	D	M	M	Y	Y	Y	Y	M	F
			D	D	M	M	Y	Y	Y	Y	M	F
			D	D	M	M	Y	Y	Y	Y	M	F
			D	D	M	M	Y	Y	Y	Y	M	F
			D	D	M	M	Y	Y	Y	Y	M	F

Departure Date: 

D	D	M	M	Y	Y	Y	Y
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 Return Date: 

D	D	M	M	Y	Y	Y	Y
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Reason for Travel: 


SIGNATURE

Signature of Applicant