



RESOLUTION

health Medical Scheme

INTERNATIONAL TRAVEL COVER NOTIFICATION FORM

This notification form must be received at the Scheme within one week following the date on which it was signed. The Scheme reserves the right to suspend this benefit and all claim payments in this regard should this notification form be incomplete.
 (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

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:

Signed at _____ on this _____ day of _____ / _____

SIGNATURE

Signature of Applicant