



RESOLUTION

health Medical Scheme

MEMBERSHIP CARD REQUEST FORM

Incomplete request forms will not be accepted. Kindly complete all sections in BLACK ink and forward your card request form to amend@resomed.co.za or fax it to 086 513 1438.

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				
Email Address:																									
Cell phone Number:										Fax Number:															
Postal Address:																									

Reason for requesting a new card: _____

Signed at _____ on this _____ day of _____ / _____

SIGNATURE

Signature of Applicant

Note: Please allow fourteen (14) days for processing and postal delivery of your card.